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THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Appointments

Appointments for October 31, 2024

Appointed to the State Board of Veterinary Medical Examiners for a term to expire August 26, 2025, Lawrence J. "Larry" Moczygemba, D.V.M. of Berclair, Texas (replacing Michael A. White, D.V.M. of Conroe, who resigned).

Appointed to the State Board of Veterinary Medical Examiners for a term to expire August 26, 2029, Stacy E. McLeod, D.V.M. of Weatherford, Texas (replacing Samantha J. "Sam" Mixon, D.V.M. of Boerne, whose term expired).

Appointed to the State Board of Veterinary Medical Examiners for a term to expire August 26, 2029, Raquel R. Olivier of Houston, Texas (Ms. Olivier is being reappointed).

Appointed to the State Board of Veterinary Medical Examiners for a term to expire August 26, 2025, Randall L. "Randy" Skaggs, D.V.M. of Perryton, Texas (Dr. Skaggs is being reappointed).

Appointments for November 1, 2024

Appointed to the State Board of Education, District 13, for a term until her successor shall be duly elected and qualified, Norma C. "Leslie" Recine of Pantego, Texas (replacing Aicha Davis of Dallas, who resigned).

Greg Abbott, Governor

TRD-202405339

Proclamation 41-4150

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, a disaster proclamation was issued on Friday, July 5, 2024, as amended later the same day and again on Saturday, July 6, 2024, certifying that Hurricane Beryl posed a threat of imminent disaster, including widespread and severe property damage, injury, and loss of life due to widespread flooding, life-threatening storm surge, damaging wind, and heavy rainfall in Anderson, Angelina, Aransas, Atascosa, Austin, Bastrop, Bee, Bell, Bexar, Bowie, Brazoria, Brazos, Brooks, Burleson, Caldwell, Calhoun, Cameron, Camp, Cass, Chambers, Cherokee, Collin, Colorado, Comal, Dallas, DeWitt, Delta, Dimmit, Duval, Ellis, Falls, Fannin, Fayette, Fort Bend, Franklin, Freestone, Frio, Galveston, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hardin, Harris, Harrison, Hays, Henderson, Hidalgo, Hill, Hopkins, Houston, Hunt, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Karnes, Kaufman, Kenedy, Kinney, Kleberg, La Salle, Lamar, Lavaca, Lee, Leon, Liberty, Limestone, Live Oak, Madison, Marion, Matagorda, Maverick, McLennan, McMullen, Medina, Milam, Montgomery, Morris, Nacogdoches, Navarro, Newton, Nueces, Orange, Panola, Polk, Rains, Red River, Refugio, Robertson, Rockwall, Rusk, Sabine, San Augustine, San Jacinto, San Patricio, Shelby, Smith, Starr, Titus, Travis, Trinity, Tyler, Upshur, Uvalde, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Wood, Zapata, and Zavala Counties;

NOW, THEREFORE, I, Greg Abbott, Governor of Texas, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, do hereby renew the aforementioned proclamation.

Pursuant to Section 418.017 of the Texas Government Code, I authorize the use of all available resources of state government and of political subdivisions that are reasonably necessary to cope with this disaster.

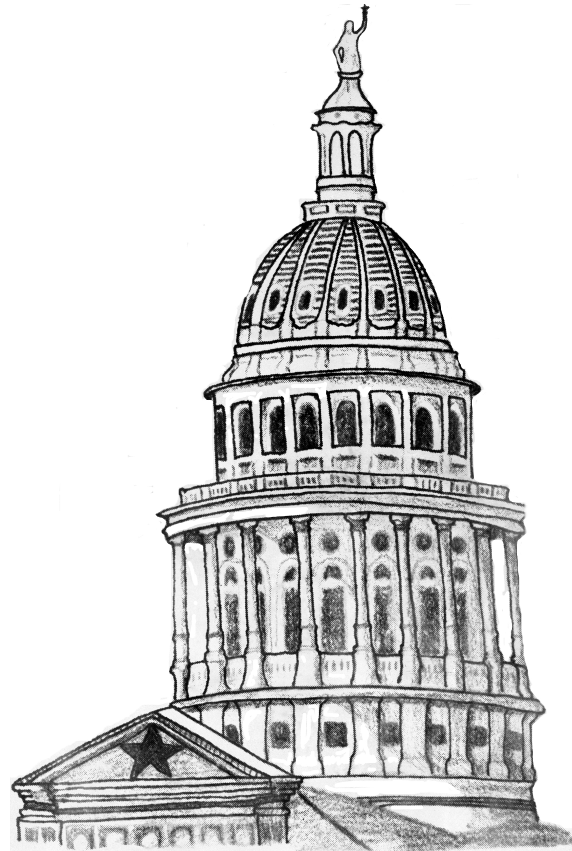
Pursuant to Section 418.016 of the Texas Government Code, any regulatory statute prescribing the procedures for conduct of state business or any order or rule of a state agency that would in any way prevent, hinder, or delay necessary action in coping with this disaster shall be suspended upon written approval of the Office of the Governor. However, to the extent that the enforcement of any state statute or administrative rule regarding contracting or procurement would impede any state agency's emergency response that is necessary to protect life or property threatened by this declared disaster, I hereby authorize the suspension of such statutes and rules for the duration of this declared disaster.

In accordance with the statutory requirements, copies of this proclamation shall be filed with the applicable authorities.

IN TESTIMONY WHEREOF, I have hereunto signed my name and have officially caused the Seal of State to be affixed at my office in the City of Austin, Texas, this the 2nd day of November, 2024.

Greg Abbott, Governor

TRD-202405314



THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, and Open Records Decisions.

An index to the full text of these documents is available on the Attorney General's website at https://www.texas.attorneygeneral.gov/attorney-general-opinions. For information about pending requests for opinions, telephone (512) 463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: https://www.texasattorneygeneral.gov/attorney-general-opinions.)

Requests for Opinions

RQ-0568-KP

Requestor:

The Honorable Brian Birdwell

Chair, Senate Committee on Natural Resources & Economic Development

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Authority of the Texas Ethics Commission to toll its obligation under Government Code section 571.1242(g) in circumstances beyond litigation (RQ-0568-KP)

Briefs requested by December 2, 2024

RQ-0569-KP

Requestor:

The Honorable J. Brett Smith

Grayson County Criminal District Attorney

200 South Crockett Street, Suite 116A

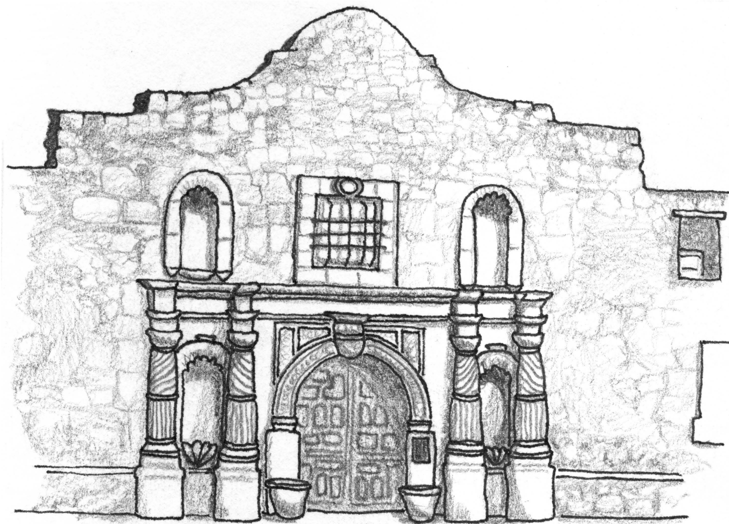
Sherman, Texas 75090

Re: Whether a county is obligated to provide emergency services to residents of unincorporated areas (RQ-0569-KP)

Briefs requested by December 2, 2024

For further information, please access the website at www.texasattorneygeneral.gov or call the Opinion Committee at (512) 463-2110.

TRD-202405322
Justin Gordon
General Counsel
Office of the Attorney General
Filed: November 5, 2024



PROPOSED RULES

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

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 351. COORDINATED PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §351.4, concerning Health and Human Services Commission Executive Council; §351.11, concerning Reports on Efforts to Streamline and Simplify Delivery of Services; §351.504, concerning Caseload Reduction Plan for Adult Protective Services; §351.507, concerning Adverse Licensing, Listing, or Registration Decisions by Health and Human Services Agencies; §351.701, concerning Unrelated Donor Umbilical Cord Blood Bank Program; §351.751, concerning Integrated eligibility services call centers; §351.801, concerning Authority and General Provisions; §351.807, concerning Behavioral Health Advisory Committee; §351.809, concerning Drug Utilization Review Board; §351.811, concerning Intellectual and Developmental Disability System Redesign Advisory Committee; §351.821, concerning Value-Based Payment and Quality Improvement Advisory Committee; §351.823, concerning e-Health Advisory Committee; §351.825, concerning Texas Brain Injury Advisory Council; §351.827, concerning Palliative Care Interdisciplinary Advisory Council; and §351.841, concerning Joint Committee on Access and Forensic Services.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

Trey Wood, HHSC Chief Financial Services 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 not create a new regulation;

(6) the proposed rules will not expand, limit, or 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.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules because the amendments only update references to existing laws.

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

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social 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 amendments only update references to existing laws.

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

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 24R084" in the subject line.

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §§351.4, 351.11, 351.504, 351.507, 351.701, 351.751

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 Chapters 521, 523, 525, 542, 546, and 549.

The amendments affect Texas Government Code §531.0055 and Chapters 521, 523, 525, 542, 546, and 549.

§351.4. Health and Human Services Commission Executive Council.

(a) Statutory authority. Texas Government Code §523.0101 [~~§531.0051~~] establishes the Health and Human Services Commission Executive Council and requires the Executive Commissioner to adopt rules for its operation.

(b) Applicability of Texas Government Code Chapter 2110. The Health and Human Services Commission Executive Council is not subject to Texas Government Code Chapter 2110.

(c) Applicability of Texas Government Code Chapter 551. The Health and Human Services Commission Executive Council is not subject to Texas Government Code Chapter 551.

(d) Definitions. For the purpose of this section, the following terms are defined as follows:

(1) Executive Commissioner--The executive commissioner of the Health and Human Services Commission.

(2) Executive Council--The Health and Human Services Commission Executive Council.

(3) Health and Human Services system--All state agencies and departments under and including the Health and Human Services Commission.

(4) HHSC--The Health and Human Services Commission.

(e) Purpose. The Executive Council is established to receive public input and advise the Executive Commissioner regarding the operation of the Health and Human Services system.

(f) Tasks. The Executive Council reviews policies related to the operation of the HHS system.

(1) The Executive Council seeks and receives public comment on:

(A) proposed rules;

(B) recommendations of advisory committees established under Subchapter B of this Chapter (relating to Advisory Committees);

(C) legislative appropriations request or other documents related to the appropriations process;

(D) the operation of health and human services programs; and

(E) other items the Executive Commissioner determines appropriate.

(2) The Executive Council does not have the authority to make administrative or policy decisions.

(g) Membership. The members of the Executive Council serve at the pleasure of the Executive Commissioner.

(1) The Executive Council is composed of:

(A) the Executive Commissioner;

(B) the director of each HHSC division established under Texas Government Code §523.0151(a) [~~§531.008(c)~~];

(C) the commissioner of each Health and Human Services system agency;

(D) other individuals appointed by the Executive Commissioner.

(2) When appointing members under paragraph (1)(D) of this subsection, the Executive Commissioner will make every effort to ensure that those appointments result in Executive Council membership that includes:

(A) a balanced representation of a broad range of health and human services industry and consumer interests; and

(B) representation from broad geographic regions of the State of Texas.

(3) Members appointed under paragraph (1)(D) of this subsection are subject to the restrictions applicable to service on the Executive Council provided by Texas Government Code §523.0104(b) [~~§531.006(a-1)~~].

(4) Terms. Members appointed under paragraph (1)(D) of this subsection will serve three-year terms.

(A) No more than half of the terms of members appointed under paragraph (1)(D) of this subsection shall expire in a single state fiscal year.

(B) If more than half of the members appointed under paragraph (1)(D) of this subsection have terms beginning in the same state fiscal year, members will draw for two- or three-year terms. Subsequent terms will be for a period of two years.

(C) Members may serve a maximum of two consecutive terms.

(h) Presiding officer. The Executive Commissioner serves as the chair of the Executive Council.

(i) Meetings. The Executive Council meets at the call of the Executive Commissioner, at least quarterly.

(1) A meeting of the individual members of the Executive Council that occurs in the ordinary course of Health and Human Services system operations is not a meeting of the Executive Council, and the provisions of subsection (j) of this section do not apply.

(2) Live video transmissions of each meeting will be publicly available through the HHSC website.

(j) Public notice. The Executive Council will give public notice of the date, time, and place of each meeting.

(k) Quorum. A majority of the members of the Executive Council constitutes a quorum for the transaction of business.

(l) Reimbursement and compensation. Members appointed under subsection (g)(1)(D) of this section may not receive compensation but are entitled to reimbursement for travel expenses incurred while conducting the business of the Executive Council, as provided by the Texas General Appropriations Act.

§351.11. Reports on Efforts to Streamline and Simplify Delivery of Services.

(a) Applicability. This section applies to state health and human services agencies as defined in Texas Government Code §521.0001 [~~§531.001(4), Government Code~~].

(b) Quarterly Reports.

(1) The executive head of each health and human services agency shall report quarterly to the governing body of the agency on the agency's efforts to streamline and simplify the delivery of services.

(2) The reports shall be presented at the governing body's regular meetings in March, June, September, and December for efforts during the previous three months. If the governing body of the agency does not hold a meeting in the designated month, then the report shall be presented at the next meeting after the designated month.

(3) Each agency shall submit a copy of the report to the Health and Human Services Commission within 15 days from the date the report was submitted to the agency's governing body.

(c) Report Content and Format.

(1) Information to be included in the report and the report format will be defined by the Health and Human Services Commission, and will include descriptions of activities that relate to streamlining and simplifying of the delivery of services.

(2) Activities that streamline and simplify the delivery of services may include, but are not limited to the following:

(A) consolidation, coordination, streamlining or simplification of administrative or support functions, including use of automation or the Internet;

(B) state/local collaborations or partnerships;

(C) coordination or collaboration initiatives with other state agencies;

(D) cost-efficiency or cost-effectiveness initiatives;

(E) efforts to streamline or simplify service delivery at one or more of the following stages:

(i) planning;

(ii) eligibility determination;

(iii) intake or enrollment;

(iv) outreach, marketing, or education;

(v) implementation;

(vi) case management or referral;

(vii) quality assurance; or

(viii) evaluation;

(F) other efforts that increase consumer satisfaction.

§351.504. Caseload Reduction Plan for Adult Protective Services.

(a) Applicability. This section applies to the development by the executive commissioner of HHSC of a Caseload Reduction Plan (the Plan) for the Adult Protective Services (APS) Division of the Department of Family and Protective Services as required by Texas Government Code §526.0401 [~~§531.048, Government Code~~].

(b) Purpose of the Plan. The purpose of the Plan is to reduce caseloads for adult protective services caseworkers to a level that does not exceed professional caseload standards recommended by the National Adult Protective Services Association by more than five cases per worker by January 1, 2011. The Plan must include annual targets for caseload reduction.

(c) Components of the Plan. The Plan will include:

(1) APS program description.

(2) Assessment of program and demographic data using historic and forecasted information.

(3) Internal and external influences and impact of those influences.

(4) APS policy and operational factors influencing caseloads.

(5) Identification of options to reduce caseloads.

(6) Program impact of caseload reduction options.

(7) Resource needs and cost impact for caseload reduction options.

(8) Consultation with stakeholders.

(d) Report. Beginning in 2006, not later than December 31 of each even numbered year, a report will be prepared on the APS Caseload Reduction Plan including the amount of funding necessary in the next biennium to fully implement the Plan. The report will be provided to the governor, lieutenant governor, speaker of the house of representatives, and the presiding officer of each house and senate standing committee having jurisdiction over adult protective services.

§351.507. Adverse Licensing, Listing, or Registration Decisions by Health and Human Services Agencies.

(a) This section applies only to the final licensing, listing, or registration decisions of a health and human services agency as defined by Texas Government Code §521.0001 [~~§531.001(4), Government Code~~], with respect to a person under the law authorizing the agency to regulate the following types of persons:

(1) a youth camp licensed under Chapter 141, Health and Safety Code;

(2) a home and community support services agency licensed under Chapter 142, Health and Safety Code;

(3) a hospital licensed under Chapter 241, Health and Safety Code;

(4) an institution licensed under Chapter 242, Health and Safety Code;

(5) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(6) a special care facility licensed under Chapter 248, Health and Safety Code;

(7) an intermediate care facility licensed under Chapter 252, Health and Safety Code;

(8) a chemical dependency treatment facility licensed under Chapter 464, Health and Safety Code;

(9) a mental hospital or mental health facility licensed under Chapter 577, Health and Safety Code;

(10) a child-care facility or child-placing agency licensed under or a family home listed or registered under Chapter 42, Human Resources Code; or

(11) an adult day-care facility licensed under Chapter 103, Human Resources Code.

(b) This section applies only to an agency decision that has become final after all opportunities for appeal have been exhausted or waived.

(c) Each health and human services agency that regulates a person described by subsection (a) of this section must maintain a record of:

(1) each application for a license, including a renewal license or a license that does not expire, a listing, or a registration that is denied by the agency under the law authorizing the agency to regulate the person; and

(2) each license, listing, or registration that is revoked, suspended, or terminated by the agency under the applicable law.

(d) The record of an application required by subsection (c)(1) of this section must be maintained until the tenth anniversary of the date the application is denied. The record of the license, listing, or registration required by subsection (c)(2)of this section must be maintained until the tenth anniversary of the date of the revocation, suspension, or termination.

(e) The record required under subsection (c) of this section must include:

(1) the name and address of the applicant for a license, listing, or registration that is denied as described by subsection (c)(1) of this section;

(2) the name and address of each person listed in the application for a license, listing, or registration that is denied as described by subsection (c)(1) of this section;

(3) the name of each person determined by the applicable regulatory agency to be a controlling person of an entity for which an application, license, listing, or registration is denied, revoked, suspended, or terminated as described by subsection (c) of this section;

(4) the specific type of license, listing, or registration that was denied, revoked, suspended, or terminated by the agency;

(5) the reasons for the denial, revocation, suspension, or termination; and

(6) the period the denial, revocation, suspension, or termination was effective.

(f) Each health and human services agency that regulates a person described in subsection (a) of this section each month must provide a copy of the records maintained under this section to each other health and human services agency that regulates a person described by subsection (a) of this section. The Health and Human Services Commission (HHSC) may access the records provided or maintained under this section.

§351.701. Unrelated Donor Umbilical Cord Blood Bank Program.

(a) Purpose. This section establishes a program to award funding for an unrelated donor umbilical cord blood bank in Texas.

(b) Funding objectives. The funding awarded pursuant to this section is intended to improve public health in Texas through obtaining efficiently delivered services for gathering and retaining unrelated umbilical cord blood from live births for the primary purpose of making the cord blood available for transplantation purposes.

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

(1) Blood bank--A facility that:

(A) obtains a human umbilical cord blood donation from an unrelated donor;

(B) is licensed, certified, or accredited as a blood bank, blood and tissue center, laboratory, or other health care facility and is authorized by:

(i) state and/or federal law, rule, or regulation;

(ii) the American Association of Blood Banks; and

(iii) International Organization of Standardization to collect, process, and preserve human umbilical cord blood donations; and

(C) is operated in compliance with professionally recognized standards regarding quality and safety of collection of human umbilical cord blood donations, including the American Association of Blood Banks and International Organization of Standardization.

(2) Commission--The Texas Health and Human Services Commission or its designee.

(3) Contractor--The recipient of the funding awarded under this section.

(4) Donation--Human umbilical cord blood obtained from an unrelated donor and resulting from a live birth.

(5) Services--Umbilical cord blood collection, storage, preservation, and/or processing services provided by a blood bank.

(6) Unrelated donor--A person who:

(A) is legally authorized or competent;

(B) voluntarily provides a donation; and

(C) is not related by affinity or consanguinity (as determined under Chapter 573, Texas Government Code) to the recipient of the donation.

(7) Unrelated Donor Umbilical Cord Blood Bank Program or Program--The Contractor-operated public blood bank program that provides for gathering and retaining umbilical cord blood for transplantation to recipients who are unrelated to the blood donors.

(d) General conditions of the funding. The funding awarded pursuant to this section, and any extension, continuation, or addition to such funding, is subject to:

(1) the availability of appropriated state funds;

(2) an award process as established by the commission;

(3) the requirements of Texas Government Code Chapter 521 [~~Chapter 531, Texas Government Code~~], and any administrative

rules adopted thereunder, including Chapter 391 of this title (relating to Purchase of Goods and Services by the Texas Health and Human Services Commission);

(4) the requirements of the contract executed by the commission with the Contractor as required under subsection (f) of this section; and

(5) an audit by the commission, the State Auditor's Office, or an entity approved by the commission of the Contractor's performance of the services or compliance with applicable auditing standards and State and federal law;

(e) Applicant eligibility criteria. To be eligible for the funding awarded under this section, a blood bank must, at a minimum, demonstrate:

(1) the ability to establish, operate, and maintain an unrelated donor umbilical cord blood bank in Texas and to provide related services, including experience operating similar facilities in this state.

(2) possession of an appropriate, current license, certification, or certificate of good standing to operate as a blood bank from the American Association of Blood Banks and International Organization of Standardization;

(3) a plan to continue the operation of the unrelated donor umbilical cord blood bank beyond the term of the contract required by subsection (f) of this section, including an appropriate financial plan;

(4) the financial stability and resources sufficient to ensure the achievement of the funding objectives and operation of the unrelated donor umbilical cord blood bank;

(5) appropriate skills, qualifications, financial resources, and experience necessary to perform the services and provide the deliverables (both of which are specified in the contract entered under subsection (f) of this section) in an efficient and cost-effective manner, with the highest degree of quality and responsiveness within the context of the requirements of the contract; and

(6) policies relating to non-discrimination regarding the selection and treatment of donors and recipients of donations on the basis of race, sex, national origin, or ability to pay.

(f) Contract. The Contractor must enter into a contract with the commission that requires, among other things, the Contractor to:

(1) operate and maintain an unrelated donor umbilical cord blood bank in this state in accordance with standards described in subsection (c)(1) of this section;

(2) gather, collect, and preserve umbilical cord blood from live births only;

(3) comply with any financial or reporting requirements imposed on the Contractor specified in the contract; and

(4) comply with all applicable federal and state laws and their implementing regulations.

§351.751. Integrated eligibility services call centers.

(a) Applicability. This section applies to integrated eligibility services call centers established by the Health and Human Services Commission ("HHSC") after June 1, 2004.

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

(1) "Applicant" means a person who asks HHSC to determine, certify, or recertify his or her eligibility for a service.

(2) "Call center" means a place where HHSC or an HHSC contractor receives and responds to applicants' telephone inquiries and processes information in order to assist HHSC to determine, certify, or recertify an applicant's eligibility for a service.

(3) "Contractor" means a public or private entity that is awarded a contract to provide call center services under this section.

(4) "Service" means a benefit or assistance provided under any of the following programs:

(A) the Children's Health Insurance Program ("CHIP") established under Chapter 62, Health and Safety Code;

(B) the Temporary Assistance to Needy Families ("TANF") program established under Chapter 31, Human Resources Code;

(C) the Medicaid program established under Chapter 32, Human Resources Code;

(D) the nutritional assistance programs established under Chapter 33, Human Resources Code, including the Food Stamp Program;

(E) long-term care services, as defined by Section 22.0011, Human Resources Code;

(F) community-based support services identified or provided in accordance with Texas Government Code §546.0152 [~~Section 531.02481, Government Code~~]; and

(G) any other health and human services program that HHSC determines is appropriate to include as part of a call center service.

(c) Establishment and number of call centers.

(1) HHSC must establish at least one but not more than four call centers if HHSC determines that it is cost-effective to establish such call centers subject to subsections (c)(2) through (c)(4) of this section.

(2) Subject to subsection (d), HHSC must contract with at least one but not more than four private entities for the operation of call centers identified in subsection (c)(1) of this section, unless HHSC determines that contracting is not cost effective.

(3) HHSC must operate any call center identified under subsection (c)(1) of this section that it determines is not cost effective to contract with a private entity to operate.

(4) All eligibility calls, including overflow calls, will be processed through call centers located in Texas.

(5) Each call center established under this section must provide translation and interpretation services as required by federal law.

(6) HHSC will conduct one or more public hearings around the state before it establishes any call center under this section.

(d) Contracting requirements.

(1) Any contract for call center services will be competitively procured in compliance with Section 2155.144, Government Code; HHSC administrative rules codified at 1 TAC chapter 391; and applicable federal laws and regulations.

(2) Any contract for call center services that HHSC awards under this section must include, at a minimum:

(A) Performance requirements that describe the specific services to be performed by a contractor;

(B) Terms and conditions that are expressly required by state or federal laws, rules or regulations; and

(C) Any other provision that HHSC determines is necessary or beneficial to the State of Texas including, but not limited to, HHSC's Uniform Contract Terms and Conditions published on the HHSC Internet web site.

(e) Performance standards and measurement.

(1) HHSC must develop performance standards to govern the operation of each call center that address, at a minimum:

(A) The call center's ability to serve consumers in a timely manner;

(B) Quality and accuracy of eligibility determinations conducted through the call center;

(C) Courtesy, friendliness, training, and knowledge of call center staff;

(D) The call center's management of consumer and public complaints;

(E) Consumer satisfaction with the call center's services;

(F) The accessibility and usability of eligibility call center web sites, including compliance with 1 TAC §206.2, Accessibility and Usability of State Web Sites, and Texas Government Code §525.0252 [~~Government Code §531.0162, Use of Technology~~]; and

(G) Any other standard that HHSC determines is necessary to ensure the desired or expected levels and quality of call center services.

(2) HHSC must develop mechanisms for measuring the operation of each call center and to evaluate call centers' compliance with all performance standards.

(3) HHSC may establish performance standards and measurements for a contracted call center under a competitive procurement

(4) HHSC will publish all call center performance standards and measures.

(f) Establishment of eligibility by personal appearance.

(1) This subsection does not apply to an applicant whose eligibility must be established or who must be certified or recertified through a face-to-face interview under federal law or to an applicant for CHIP services.

(2) An applicant may request the opportunity to appear in person to establish initial eligibility for a service or for certification or recertification purposes.

(3) If an applicant wishes to appear personally to assist HHSC to determine, certify, or recertify his or her eligibility for a service, the applicant must notify HHSC or the health and human services agency that administers the program. An applicant may provide notice in any of the following ways:

(A) In person at an office of the health and human services agency that administers the program;

(B) In writing by using materials that HHSC provides for this purpose or by any other written method;

(C) By telephone using a toll-free number that HHSC acquires for this purpose; or

(D) By an electronic method that HHSC creates for this purpose, including facsimile and electronic mail.

(4) HHSC or its contractor will schedule a personal appearance upon request unless HHSC can establish the applicant's eligibility without a personal appearance. The personal appearance will be scheduled at a time and location that reasonably accommodates the applicant's schedule, location, and circumstances.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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SUBCHAPTER B. ADVISORY COMMITTEES
DIVISION 1. COMMITTEES

1 TAC §§351.801, 351.807, 351.809, 351.811, 351.821, 351.823, 351.825, 351.827, 351.841

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 Chapters 521, 523, 525, 542, 546, and 549.

The amendments affect Texas Government Code §531.0055 and Chapters 521, 523, 525, 542, 546, and 549.

§351.801. Authority and General Provisions.

(a) Authority to establish advisory committees. In addition to specific statutory authority to establish particular advisory committees, the Texas Health and Human Services Commission has authority under Texas Government Code §523.0201 [~~§531.012~~] to establish and maintain advisory committees to consider issues and solicit public input across all major areas of the health and human services system.

(b) Applicability of Texas Government Code Chapter 2110. An advisory committee established under Texas Government Code §523.0201 [~~§531.012~~] is subject to Texas Government Code Chapter 2110. An advisory committee established under another statute is subject to Texas Government Code Chapter 2110 unless the establishing statute expressly states otherwise.

(c) Applicability of Texas Government Code Chapter 551. Unless otherwise expressly provided by statute or rule, an advisory committee established under this subchapter is subject to the Open Meetings Act, Texas Government Code Chapter 551, as if it were a governmental body.

(d) Quorum. Unless expressly provided otherwise, a majority of an advisory committee's voting members constitutes a quorum.

(e) General reporting requirement. In addition to reporting requirements set out in an advisory committee's section of this subchapter, an advisory committee established under Texas Government Code §523.0201 [~~§531.012~~] must:

(1) report recommendations to the Executive Commissioner and the Health and Human Services Commission Executive Council; and

(2) submit a written report to the Texas Legislature of any policy recommendations made under paragraph (1) of this subsection.

(f) Geographic diversity generally. As necessary and appropriate, the members of an advisory committee established under Texas Government Code §523.0201 [~~§531.012~~] will be appointed with a view to having committee members from diverse geographic areas of the state.

(g) Definitions. For purposes of this subchapter, the following terms are defined as follows:

(1) C.F.R.--Code of Federal Regulations.

(2) CHIP--The Texas State Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. §§1397aa, et seq.) and Chapter 62 of the Texas Health and Safety Code.

(3) Executive Commissioner--The HHSC Executive Commissioner.

(4) Family member--A parent, spouse, grandparent, adult sibling, adult child, guardian, or legally authorized representative.

(5) Health and Human Services system--The Texas Health and Human Services Commission and the Texas Department of State Health Services. For purposes of this subchapter, the term also may include the Texas Department of Family and Protective Services, where appropriate.

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

(7) U.S.C.--United States Code.

§351.807. Behavioral Health Advisory Committee.

(a) Statutory authority. The Behavioral Health Advisory Committee (BHAC) is established under Texas Government Code §523.0201[~~, §531.012~~] in accordance with the State's obligations under 42 U.S.C. §300x-3, and is subject to §351.801 of this subchapter (relating to Authority and General Provisions).

(b) Purpose. The BHAC advises the HHSC Executive Commissioner on mental health and substance use disorder services in Texas.

(c) Tasks. The BHAC considers and makes recommendations to the Executive Commissioner consistent with the committee's purpose.

(d) Reporting requirements. The BHAC submits an annual written report to the Executive Commissioner and the Texas Legislature of any policy recommendations made to the Executive Commissioner.

(e) Open meetings. The BHAC complies with the requirements for open meetings under Texas Government Code, Chapter 551.

(f) Membership. The BHAC is composed of 19 voting members appointed by the Executive Commissioner and one ex officio member.

(1) The BHAC consists of representatives of the following constituencies:

(A) one adult who received, or is receiving, services for mental health or co-occurring mental health and substance use issues;

(B) one adult who received, or is receiving, services for substance use or co-occurring mental health and substance use issues;

(C) one youth/young adult who received, or is receiving, services for mental health, substance use, or co-occurring mental health and substance use issues;

(D) one family representative of someone who has received, or is receiving services for mental health, substance use, or co-occurring mental health and substance use issues;

(E) one parent of a child who has received, or is receiving, services for serious emotional disturbance;

(F) one certified peer provider;

(G) one representative nominated by the Texas Council of Community Centers;

(H) one representative nominated by the Association of Substance Abuse Programs;

(I) two independent community behavioral health service providers, one of which provides services to families;

(J) two behavioral health advocates or representatives of behavioral health advocacy organizations;

(K) one representative from a faith-based community organization;

(L) one representative of a managed care organization that contracts with HHSC;

(M) two representatives of local government;

(N) one representative from a federally recognized Native American tribe located in Texas (Alabama-Coushatta Tribe of Texas, The Kickapoo Traditional Tribe of Texas, or Ysleta Del Sur Pueblo); and

(O) up to two additional members who have demonstrated an interest in mental and substance use disorders health systems and a working knowledge of mental and substance use disorder health issues.

(2) A member of the Statewide Behavioral Health Coordinating Council, representing state agencies providing behavioral health services or funding, will serve as a non-voting, ex officio member.

(3) Members are appointed for staggered terms so that the terms of an equal or almost equal number of members expire on August 31st of each year. Each member is appointed to serve a term of three years. Regardless of term limit, a member serves until his or her replacement has been appointed. This ensures sufficient, appropriate representation.

(4) If a vacancy occurs, a person is appointed to serve the unexpired portion of that term.

(5) This subsection does not apply to ex officio members, who serve at the pleasure of the Executive Commissioner.

(g) Presiding officers. The BHAC selects a chair and co-chair of the committee from its members.

(1) Unless reelected, the chair and co-chair each serve a term of one year.

(2) A member serves no more than two consecutive terms as chair or co-chair. A chair or co-chair may not serve beyond their membership term.

(h) Required Training. Each member shall complete all training on relevant statutes and rules, including this section and §351.801

of this subchapter and Texas Government Code §523.0201[~~, §531.012~~], and Chapters 551 and 2110. Training will be provided by HHSC.

(i) Date of abolition. The BHAC is required by federal law and will continue as long as the federal law that requires it remains in effect.

§351.809. Drug Utilization Review Board.

(a) Statutory authority. 42 C.F.R. §456.716 and Texas Government Code Chapter 549, Subchapter G requires [~~§531.0736 require~~] HHSC to establish the Drug Utilization Review (DUR Board).

(b) Cross-reference. The DUR Board is governed by rules set out in §354.1941 of this title (relating to Drug Utilization Review Board).

§351.811. Intellectual and Developmental Disability System Redesign Advisory Committee.

(a) Statutory authority. Texas Government Code §542.0052 [~~§534.053~~] establishes the Intellectual and Developmental Disability System Redesign Advisory Committee (IDD-SRAC).

(b) Purpose. IDD-SRAC advises HHSC and the Texas Department of Aging and Disability Services (DADS) on the implementation of the acute care services and long-term services and supports system redesign.

(c) Tasks. In addition to the tasks required by statute, the IDD-SRAC:

(1) provides recommendations for the continued implementation of and improvements to the acute care and long-term services and supports system; and

(2) performs other tasks consistent with its purpose as requested by the Executive Commissioner.

(d) Reporting requirements. The IDD-SRAC includes its recommendations in an annual report that HHSC prepares and submits to the Texas Legislature in compliance with Texas Government Code §542.0054 [~~§534.054~~]. The report is due on or before September 30th of 2018, 2019, and 2020.

(e) Abolition. The IDD-SRAC is abolished, and this section expires, on the one-year anniversary of the date HHSC completes the transition required by Texas Government Code §542.0201 [~~§534.202~~] or January 1, 2026, whichever comes first.

(f) Membership.

(1) Each member of the IDD-SRAC is appointed jointly by the Executive Commissioner and the Commissioner of the Texas Department of Aging and Disability Services.

(2) Membership is allocated consistently with Texas Government Code §542.0052 [~~§534.053~~].

(3) Members serve at the will of the Executive Commissioner and the Commissioner of the Texas Department of Aging and Disability Services.

(g) Presiding officer. The Executive Commissioner appoints a presiding officer.

§351.821. Value-Based Payment and Quality Improvement Advisory Committee.

(a) Statutory authority. The Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) is established under Texas Government Code §523.0201 [~~§531.012~~] and is subject to §351.801 of this division (relating to Authority and General Provisions).

(b) Purpose. The VBPQIAC advises the Texas Health and Human Services (HHSC) Executive Commissioner and Health and Human Services system agencies (HHS agencies) on quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system.

(c) Tasks. The VBPQIAC performs the following tasks:

(1) studies and makes recommendations regarding:

(A) value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services;

(B) core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid and CHIP;

(C) HHSC and managed care organization incentive and disincentive programs based on value; and

(D) the strategic direction for Medicaid and CHIP value-based programs; and

(2) adopts bylaws to guide the operation of the committee; and

(3) pursues other deliverables consistent with its purpose to improve quality and efficiency in state health care services as requested by the HHSC Executive Commissioner or adopted into the work plan or bylaws of the committee.

(d) Reporting Requirements.

(1) No later than December 31st of each year, the VBPQIAC files an annual written report with the HHSC Executive Commissioner covering the meetings and activities in the immediately preceding year. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of the actions taken by the VBPQIAC;

(D) a description of how the committee accomplished its tasks;

(E) a description of the activities the VBPQIAC anticipates undertaking in the next year;

(F) recommended amendments to this section; and

(G) the costs related to the VBPQIAC, including the cost of HHSC staff time spent supporting the VBPQIAC's activities and the source of funds used to support the VBPQIAC's activities.

(2) No later than December 1st of each even-numbered year, the VBPQIAC submits a written report to the HHSC Executive Commissioner and Texas Legislature that:

(A) describes current trends and identifies best practices in health care for value-based payment and quality improvement; and

(B) provides recommendations consistent with the purposes of the VBPQIAC.

(e) Meetings.

(1) Open meetings. The VBPQIAC complies with the requirements for open meetings under Texas Government Code Chapter 551, as if it were a governmental body.

(2) Frequency. The VBPQIAC will meet at least twice each year.

(3) Quorum. A majority of members constitutes a quorum for the purpose of transacting official business. (To calculate a majority for a committee with an even number of members, divide the membership by two and add one; for a committee with an odd number of members, divide the membership by two and round up to the next whole number.)

(f) Membership.

(1) The VBPQIAC is composed of 19 voting members and up to four non-voting ex officio members appointed by the HHSC Executive Commissioner. In selecting members to serve on the VBPQIAC, HHSC considers the applicants' qualifications, background, and interest in serving.

(A) The 19 voting members represent the following categories:

(i) Medicaid managed care organizations;

(ii) hospitals;

(iii) physicians;

(iv) nurses;

(v) pharmacies;

(vi) providers of long-term services and supports;

(vii) academic systems; and

(viii) other disciplines or organizations with expertise in health care finance, delivery, or quality improvement.

(B) Four non-voting, ex officio members may be appointed to the VBPQIAC as determined by the HHSC Executive Commissioner.

(2) In selecting voting members, the Executive Commissioner considers ethnic and minority representation and geographic representation.

(3) Members are appointed for staggered terms so that the terms of an equal or almost equal number of members expire on December 31 of each year. Regardless of the term limit, a member serves until his or her replacement has been appointed. This ensures sufficient, appropriate representation.

(A) If a vacancy occurs, the HHSC Executive Commissioner will appoint a person to serve the unexpired portion of that term.

(B) Except as necessary to stagger terms, the term of each member is four years. A member may apply to serve one additional term.

(C) This subsection does not apply to ex officio members, who serve at the pleasure of the HHSC Executive Commissioner and do not have the authority to vote on items before the full committee.

(g) Officers. The VBPQIAC selects a chair and vice chair of the committee from among its members.

(1) The chair serves until December 31 of each odd-numbered year. The vice chair serves until December 31 of each even-numbered year.

(2) A member may serve up to two consecutive terms as chair or vice chair.

(3) A member is not eligible to serve in the role of chair or vice chair once another person has been appointed to fill the member's position on the VBPQIAC.

(h) Required Training. Each member must complete training on relevant statutes and rules, including this section, §351.801 of this division, Texas Government Code §523.0201 [~~§531.012~~], Texas Government Code Chapters 551, 552, and 2110, the HHS Ethics Policy, and other relevant HHS policies. Training will be provided by HHSC.

(i) Travel Reimbursement. Unless permitted by the current General Appropriations Act, members of the VBPQIAC are not paid to participate in the VBPQIAC nor reimbursed for travel to and from meetings.

(j) Date of abolition. The VBPQIAC is abolished and this section expires on December 31, 2027.

§351.823. e-Health Advisory Committee.

(a) Statutory authority. The e-Health Advisory Committee (committee) is established under Texas Government Code §523.0201 [~~§531.012~~] and is subject to §351.801 of this division (relating to Authority and General Provisions).

(b) Purpose. The committee advises the Texas Health and Human Services Commission (HHSC) Executive Commissioner and Health and Human Services system agencies (HHS agencies) on strategic planning, policy, rules, and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services.

(c) Tasks. The committee:

(1) advises HHS agencies on the development, implementation, and long-range plans for health care information technology and health information exchange, including the use of electronic health records, computerized clinical support systems, health information exchange systems for exchanging clinical and other types of health information, and other methods of incorporating health information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care and population health;

(2) advises HHS agencies on incentives for increasing health care provider adoption and usage of an electronic health record and health information exchange systems;

(3) advises HHS agencies on the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services, including consultations, reimbursements, and new benefits for inclusion in Medicaid telemedicine, telehealth, and home telemonitoring programs;

(4) makes recommendations to HHS agencies through regularly scheduled meetings and verbal or written recommendations communicated to HHSC staff assigned to the committee;

(5) performs other tasks consistent with its purpose as requested by the Executive Commissioner; and

(6) adopts bylaws to guide the operation of the committee.

(d) Reporting Requirements.

(1) No later than December 1 of each even-numbered year, the committee files a written report with the HHSC Executive Commissioner and the Texas Legislature covering the meetings and activities not covered in its most recent report filed with the HHSC Executive Commissioner and Texas Legislature through September 30 of the even-numbered year the report is due to be filed. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the committee;

(D) a description of how the committee accomplished its tasks;

(E) a summary of the status of any rules that the committee recommended to HHSC;

(F) a description of activities the committee anticipates undertaking in the next fiscal year;

(G) recommended amendments to this section;

(H) any policy recommendations; and

(I) the costs related to the committee, including the cost of HHSC staff time spent supporting the committee's activities and the source of funds used to support the committee's activities.

(2) No later than December 1 of each odd-numbered year, the committee submits to the HHSC Executive Commissioner an informational briefing memorandum describing the committee's costs, accomplishments, and areas of focus that covers October 1 of the preceding year through September 30 of the odd-numbered year the informational briefing memorandum is due to be filed.

(e) Meetings.

(1) Open meetings. The committee complies with the requirements for open meetings under Texas Government Code Chapter 551, as if it were a governmental body.

(2) Frequency. The committee will meet at least three times a year at the call of the presiding officer.

(3) Quorum. A majority of members constitutes a quorum.

(f) Membership.

(1) The committee is composed of no more than 24 members appointed by the HHSC Executive Commissioner. In selecting members to serve on the committee, HHSC considers the applicants' qualifications, background, and interest in serving.

(2) The committee includes representatives of HHS agencies, other state agencies, and other health and human services stakeholders concerned with the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services. The committee comprises the following voting and non-voting ex officio members:

(A) Voting members representing the following categories:

(i) at least one representative from the Texas Medical Board;

(ii) at least one representative from the Texas Board of Nursing;

(iii) at least one representative from the Texas State Board of Pharmacy;

(iv) at least one representative from the Statewide Health Coordinating Council;

(v) at least one representative of a managed care organization;

(vi) at least one representative of the pharmaceutical industry;

(vii) at least one representative of a health science center in Texas;

(viii) at least one expert on telemedicine;

(ix) at least one expert on home telemonitoring services;

(x) at least one representative of consumers of health services provided through telemedicine;

(xi) at least one Medicaid provider or child health plan program provider;

(xii) at least one representative from the Texas Health Services Authority established under Texas Health and Safety Code Chapter 182;

(xiii) at least one representative of a local or regional health information exchange; and

(xiv) at least one representative with expertise related to the implementation of electronic health records, computerized clinical support systems, and health information exchange systems for exchanging clinical and other types of health information.

(B) Non-voting ex officio members representing the following categories:

(i) at least two non-voting ex officio representatives from HHSC; and

(ii) at least one non-voting ex officio representative from the Texas Department of State Health Services.

(3) When appointing members, the HHSC Executive Commissioner considers the cultural, ethnic, and geographic diversity of Texas, including representation from at least 6 of the 11 Public Health Regions as defined by the Texas Department of State Health Services in accordance with Texas Health and Safety Code §121.007.

(4) Members are appointed for staggered terms so that the terms of half of the members expire on December 31st of each year. Regardless of the term limit, a member serves until the member's replacement has been appointed. This ensures sufficient, appropriate representation.

(A) If a vacancy occurs, the HHSC Executive Commissioner appoints a person to serve the unexpired portion of that term.

(B) Except as may be necessary to stagger terms, the term of each member is two years. A member may apply and be appointed for a second two-year term, which may be served consecutively or nonconsecutively.

(C) This section does not apply to non-voting ex officio members, who serve at the pleasure of the HHSC Executive Commissioner.

(g) Officers. The committee selects from its members the presiding officer and an assistant presiding officer.

(1) The presiding officer serves until July 1st of each even-numbered year. The assistant presiding officer serves until July 1 of each odd-numbered year.

(2) A member may serve up to two consecutive terms as presiding officer or assistant presiding officer.

(3) A member whose term has expired is not eligible to serve in the officer role of chair or vice chair once another person has been appointed to fill the member's position on the committee.

(h) Required Training. Each member must complete training on relevant statutes and rules, including this section; §351.801 of this subchapter; Texas Government Code §523.0201 [~~§531.012~~]; Texas Government Code Chapters 551, 552, and 2110; the HHS Ethics Pol-

icy, and other relevant HHS policies. Training will be provided by HHSC.

(i) Travel Reimbursement. Unless permitted by the current General Appropriations Act, members of the committee are not paid to participate in the committee nor reimbursed for travel to and from meetings.

(j) Date of abolition. The committee is abolished and this section expires on December 31, 2025.

§351.825. Texas Brain Injury Advisory Council.

(a) Statutory authority. The Texas Brain Injury Advisory Council (TBIAC) is established under Texas Government Code §523.0201 [~~§531.012~~] and is subject to §351.801 of this division (relating to Authority and General Provisions).

(b) Purpose. The TBIAC advises the Texas Health and Human Services Commission (HHSC) Executive Commissioner and the Health and Human Services system on strategic planning, policy, rules, and services related to the prevention of brain injury; rehabilitation; and the provision of long-term services and supports for persons who have survived brain injuries to improve their quality of life and ability to function independently in the home and community.

(c) Tasks. The TBIAC performs the following tasks:

(1) informs state leadership of the needs of persons who have survived a brain injury and their families regarding rehabilitation and the provision of long-term services and supports to improve health and functioning that leads to achieving maximum independence in home and community living and participation;

(2) encourages research into the causes and effects of brain injuries as well as promising and best practice approaches for prevention, early intervention, treatment and care of brain injuries and the provision of long-term services and supports;

(3) recommends policies that facilitate the implementation of the most current promising and evidence-based practices for the care, rehabilitation, and the provision of long-term services and supports to persons who have survived a brain injury;

(4) promotes brain injury awareness, education, and implementation of health promotion and prevention strategies across Texas;

(5) facilitates the development of partnerships among diverse public and private provider and consumer stakeholder groups to develop and implement sustainable service and support strategies that meet the complex needs of persons who have survived a brain injury and those experiencing co-occurring conditions; and

(6) adopts bylaws to guide the operation of the TBIAC.

(d) Reporting requirements.

(1) Reporting to the HHSC Executive Commissioner. By November 1 of each year, the TBIAC files an annual written report with the HHSC Executive Commissioner covering the meetings and activities in the immediately preceding fiscal year and reports any recommendations to the HHSC Executive Commissioner at a meeting of the Texas Health and Human Services Commission Executive Council. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the TBIAC;

(D) a description of how the TBIAC accomplished its tasks;

(E) a description of activities the TBIAC anticipates undertaking in the next fiscal year;

(F) recommendations made by the TBIAC, if any;

(G) recommended amendments to this section; and

(H) the costs related to the TBIAC, including the cost of HHSC staff time spent supporting the TBIAC's activities and the source of funds used to support the TBIAC's activities.

(2) Reporting to Texas Legislature. The TBIAC shall submit a written report to the Texas Legislature of any policy recommendations made to the HHSC Executive Commissioner by December 1 of each even-numbered year.

(e) Meetings.

(1) Open Meetings. The TBIAC complies with the requirements for open meetings under Texas Government Code Chapter 551 as if it were a governmental body.

(2) Frequency. The TBIAC will meet quarterly.

(3) Quorum. Eight members constitute a quorum.

(f) Membership.

(1) The TBIAC is composed of 15 members appointed by the HHSC Executive Commissioner representing the categories below. In selecting members to serve on the TBIAC, HHSC considers the applicants' qualifications, background, geographic location, and interest in serving.

(A) One representative from acute hospital trauma units.

(B) One representative from post-acute rehabilitation facilities.

(C) One representative of a long-term care facility that serves persons who have survived a brain injury.

(D) One healthcare practitioner or service provider who has specialized training or interest in the prevention of brain injuries or the care, treatment, and rehabilitation of persons who have survived a brain injury.

(E) One representative of an institution of higher education engaged in research that impacts persons who have survived a brain injury.

(F) Five persons who have survived a brain injury representing diverse ethnic or cultural groups and geographic regions of Texas, with:

(i) at least one of these being a transition age youth (age 18-26);

(ii) at least one of these being a person who has survived a traumatic brain injury; and

(iii) at least one of these being a person who has survived a non-traumatic brain injury.

(G) Four family members actively involved in the care of loved ones who have sustained a brain injury, with:

(i) at least one of these being a person whose loved one has survived a traumatic brain injury; and

(ii) at least one of these being a person whose loved one has survived a non-traumatic brain injury.

(H) One representative from the stroke committee of the Governor's Emergency Medical Services (EMS) & Trauma Advisory Council or other stakeholder group with a focus on stroke.

(2) Members are appointed for staggered terms so that the terms of five, or almost five, members expire on December 31 of each year. Regardless of the term limit, a member serves until his or her replacement has been appointed. This ensures sufficient, appropriate representation.

(A) If a vacancy occurs, the HHSC Executive Commissioner will appoint a person to serve the unexpired portion of that term.

(B) Except as may be necessary to stagger terms, the term of each member is three years. A member may apply to serve one additional term.

(g) Officers. The TBIAC selects a chair and vice chair of the TBIAC from among its members. The chair or the vice chair must be a person who has survived a brain injury or a family member actively involved in the care of a loved one who has survived a brain injury.

(1) The chair serves until December 31 of each even-numbered year. The vice chair serves until December 31 of each odd-numbered year.

(2) A member may serve up to two consecutive terms as chair or vice chair.

(h) Required Training. Each member must complete training on relevant statutes and rules, including this section and §351.801 of this division; Texas Government Code §523.0201 [~~§531.012~~], Chapters 551, 552, and 2110; the HHS Ethics Policy; the Advisory Committee Member Code of Conduct; and other relevant HHS policies. Training will be provided by HHSC.

(i) Travel Reimbursement. To the extent permitted by the current General Appropriations Act, a member of the TBIAC may be reimbursed for their travel to and from meetings if funds are appropriated and available and in accordance with the HHSC Travel Policy.

(j) Date of abolition. The TBIAC is abolished and this section expires on July 1, 2028, in compliance with Texas Government Code §2110.008(b).

§351.827. Palliative Care Interdisciplinary Advisory Council.

(a) Statutory authority. The Palliative Care Interdisciplinary Advisory Council (Council) is established in accordance with Texas Health and Safety Code Chapter 118.

(b) Purpose. The Council assesses the availability of patient-centered and family-focused, interdisciplinary team-based palliative care in Texas for patients and families facing serious illness. The Council works to ensure that relevant, comprehensive, and accurate information and education about palliative care is available to the public, health care providers, and health care facilities. This includes information and education about complex symptom management, care planning, and coordination needed to address the physical, emotional, social, and spiritual suffering associated with serious illness.

(c) Tasks. The Council performs the following tasks:

(1) consults with and advises HHSC on matters related to the establishment, maintenance, operation, and outcome evaluation of the palliative care consumer and professional information and education program established under Texas Health and Safety Code §118.011;

(2) studies and makes recommendations to remove barriers to appropriate palliative care services for patients and families facing serious illness in Texas of any age and at any stage of illness; and

(3) pursues other deliverables consistent with its purpose as requested by the Executive Commissioner or adopted into the work plan or bylaws of the council.

(d) Reporting requirements.

(1) Reporting to Executive Commissioner. By December 31 of each year, the Council files a written report with the Executive Commissioner that covers the meetings and activities in the immediately preceding fiscal year. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the committee;

(D) a description of how the committee accomplished its tasks;

(E) a summary of the status of any rules that the committee recommended to HHSC;

(F) a description of activities the committee anticipates undertaking in the next fiscal year;

(G) recommended amendments to this section; and

(H) the costs related to the committee, including the cost of HHSC staff time spent supporting the committee's activities and the source of funds used to support the committee's activities.

(2) Reporting to Executive Commissioner and Texas Legislature. By October 1 of each even-numbered year, the Council submits a written report to the Executive Commissioner and the standing committees of the Texas senate and house with primary jurisdiction over health matters. The report:

(A) assesses the availability of palliative care in Texas for patients in the early stages of serious disease;

(B) analyzes barriers to greater access to palliative care;

(C) analyzes policies, practices, and protocols in Texas concerning patients' rights related to palliative care, including:

(i) whether a palliative care team member may introduce palliative care options to a patient without the consent of the patient's attending physician or practitioner;

(ii) the practices and protocols for discussions between a palliative care team member and a patient on life-sustaining treatment or advance directives decisions; and

(iii) the practices and protocols on informed consent and disclosure requirements for palliative care services; and

(D) provides recommendations consistent with the purposes of the Council.

(e) Open meetings. The Council complies with the requirements for open meetings under Texas Government Code Chapter 551 as if it were a governmental body.

(f) Membership.

(1) The Council is composed of at least 15 voting members appointed by the Executive Commissioner and nonvoting agency, ex officio representatives as determined by the Executive Commissioner. Total membership on the Council will not exceed 24.

(2) Voting membership.

(A) The Council must include:

(i) at least five physician members, including:

(I) two who are board certified in hospice and palliative care; and

(II) one who is board certified in pain management;

(ii) three palliative care practitioner members, including:

(I) two advanced practice registered nurses who are board-certified in hospice and palliative care; and

(II) one physician assistant who has experience providing palliative care;

(iii) four health care professional members, including:

(I) a nurse;

(II) a social worker;

(III) a pharmacist; and

(IV) a spiritual-care professional; and

(iv) at least three members:

(I) with experience as an advocate for patients and the patients' family caregivers;

(II) who are independent of a hospital or other health care facility; and

(III) at least one of whom represents an established patient advocacy organization.

(B) Health care professional members listed in subparagraph (A)(iii) of this paragraph must meet one or more of the following qualifications:

(i) experience providing palliative care to pediatric, youth, or adult populations;

(ii) expertise in palliative care delivery in an inpatient, outpatient, or community setting; or

(iii) expertise in interdisciplinary palliative care.

(C) In selecting voting members, the Executive Commissioner considers ethnic and minority representation and geographic representation.

(D) Members are appointed to staggered terms so that the terms of approximately one-quarter of the members' terms expire on December 31 of each year.

(E) Except as necessary to stagger terms, the term of each voting member is four years.

(g) Officers. The Council selects from its members a presiding officer and an assistant presiding officer.

(1) The presiding officer serves until December 31 of each odd-numbered year. The assistant presiding officer serves until December 31 of each even-numbered year.

(2) The presiding officer and the assistant presiding officer remain in their positions until the Council selects a successor; however, the individual may not remain in office past the individual's membership term.

(h) Required Training. Each member shall complete all training on relevant statutes and rules, including this section and §351.801 of this subchapter (relating to Authority and General Provisions) and Texas Government Code §523.0201 [~~§531.012~~], and Texas Government Code Chapters 551 and 2110. HHSC will provide the training.

(i) Abolition. The Council is required by statute and will continue as long as the state law that requires it remains in effect.

§351.841. Joint Committee on Access and Forensic Services.

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

(1) Executive Commissioner--The Executive Commissioner of the Texas Health and Human Services Commission or the Executive Commissioner's designee.

(2) Forensic patient--The term has the meaning described in Texas Health and Safety Code Chapter 532.013.

(3) Forensic services--A competency examination, competency restoration service, or mental health service provided to a current or former forensic patient in the community or at a facility that receives state funds for providing mental health services for forensic patients.

(4) HHSC--The Texas Health and Human Services Commission.

(5) JCAFS--The Joint Committee on Access and Forensic Services.

(b) Statutory authority. JCAFS is authorized by:

(1) Texas Health and Safety Code §533.051(c), which defines membership requirements and prescribes the duties of the JCAFS; and

(2) Texas Health and Safety Code §533.0515, which authorizes the Executive Commissioner to adopt rules as necessary to implement its provisions.

(c) Purpose. The purpose of the JCAFS is to:

(1) make recommendations and monitor implementation of updates to a bed day allocation methodology;

(2) make recommendations and monitor implementation of a utilization review protocol for state funded beds in hospitals and other inpatient mental health facilities; and

(3) make recommendations to improve access to mental health services for both civil and forensic patients throughout the full continuum of care from institution to community-based settings.

(d) Tasks. The JCAFS considers and makes recommendations to the Executive Commissioner consistent with the committee's purpose as stated in subsection (c) of this section.

(e) Reporting requirements. The JCAFS submits:

(1) a written report to the Executive Commissioner, the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, the Senate Finance Committee, the House Appropriations Committee and the standing committees of the legislature having jurisdiction over mental health and human services by December 1 of each even-numbered year, in accordance with Texas Health and Safety Code §533.0515(e); and

(2) a proposal for an updated bed day allocation methodology and bed day utilization review protocol to the Executive Commissioner no later than December 1 of each even-numbered year, in accordance with Texas Health and Safety Code §533.015.

(f) Open meetings. The JCAFS complies with the requirements for open meetings under Texas Government Code Chapter 551.

(g) Membership. The JCAFS is composed of 17 members nominated by the designating organization and appointed by the Executive Commissioner. A majority of the voting members of the JCAFS constitutes a quorum. Each member serves until a replacement is nominated by the designating organization and appointed by the Executive Commissioner.

(1) The membership consists of:

(A) one Texas Department of Criminal Justice-designated representative;

(B) one Texas Association of Counties-designated representative;

(C) two Texas Council of Community Centers-designated representatives, including one representative of an urban local service area and one representative of a rural local service area;

(D) two County Judges and Commissioners Association of Texas-designated representatives, one of which is the presiding judge of a court with jurisdiction over mental health matters;

(E) one Sheriffs' Association of Texas-designated representative;

(F) two Texas Municipal League-designated representatives, one of which is a municipal law enforcement official;

(G) one Texas Conference of Urban Counties-designated representative;

(H) two Texas Hospital Association-designated representatives, one of which is a physician;

(I) one representative designated by an organization identified by HHSC representing individuals with lived experience receiving publicly funded mental health services; and

(J) four representatives designated by the HHSC Behavioral Health Advisory Committee (BHAC), or its successor:

(i) including the chair of the BHAC;

(ii) one representative of the BHAC's members who is a consumer of or advocate for mental health services;

(iii) one representative of the BHAC's members who is a consumer of or advocate for substance abuse treatment; and

(iv) one representative of the BHAC's members who is a family member of or advocate for persons with mental health and substance abuse disorders.

(2) The HHSC Forensic Director and the State Hospital Chief of Forensic Medicine serve as non-voting ex officio members of the JCAFS.

(h) Officers. The JCAFS selects from among its members, a presiding chair and vice-chair. Unless re-elected, the term of the presiding chair and vice-chair is one year. The chair and vice-chair will each serve no more than three one-year terms in each position.

(i) Required training. Each member shall complete all training on relevant statutes and rules, including this section, §351.801 of this subchapter (relating to Authority and General Provisions), Texas Government Code §523.0201 [~~§531.012~~], and Texas Government Code Chapters 551 and 2110. Training will be provided by HHSC.

(j) Date of abolition. The JCAFS will not be abolished as long as the Texas Health and Safety Code §533.051 and §533.0515 remain in effect because the JCAFS is established by statute.

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 October 31, 2024.

TRD-202405179
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 221-9021

CHAPTER 352. MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM PROVIDER ENROLLMENT

1 TAC §352.1, §352.3

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §352.1, concerning Purpose; and §352.3, concerning Definitions.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

Trey Wood, HHSC Chief Financial Services 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 not create a new regulation;

(6) the proposed rules will not expand, limit, or 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.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules because the amendments only update references to existing laws.

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

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social.

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 amendments only update references to existing laws.

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 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 24R084" in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapters 521 and 532.

The amendments affect Texas Government Code §531.0055 and Chapters 521 and 532.

§352.1. Purpose.

(a) The enrollment of providers in Medicaid and the Children's Health Insurance Program (CHIP) is conducted under the authority of the Texas Health and Human Services Commission (HHSC), and is administered by HHSC or its designee.

(b) The enrollment requirements in this chapter are consistent with:

(1) Title 42, Part 455, of the Code of Federal Regulations (CFR); and

(2) Texas Government Code Chapter 532 [~~Chapter 531 of the Government Code~~].

(c) Additional enrollment requirements may be found in the following authorities:

(1) Title 1, Texas Administrative Code (TAC), Part 15 (relating to Texas Health and Human Services Commission).

(2) Policy publications issued by HHSC or a health and human services agency, such as:

(A) the *Texas Medicaid Provider Procedures Manual;*

(B) each Medicaid managed care program provider or operating manual;

(C) each CHIP provider or operating manual;

(D) each health and human services agency program handbook; and

(E) each policy update and policy explanation (such as provider banners, bulletins, and quarterly updates).

(3) 40 TAC Part 1 (relating to Department of Aging and Disability Services).

(4) 40 TAC Part 2 (relating to Department of Assistive and Rehabilitative Services).

(5) 25 TAC Part 1 (relating to Department of State Health Services).

§352.3. Definitions.

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

(1) Applicant--An individual or an entity that submits an enrollment application to enroll or re-enroll as a provider or to enroll a new practice location in Medicaid or CHIP as described in paragraph (7) of this section.

(2) CHIP--The Texas State Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. §§1397aa, et seq.) and Chapter 62 of the Health and Safety Code.

(3) Change of ownership--A change of ownership related to a partnership, sole proprietorship, corporation, or leasing arrangement as defined in 42 CFR §489.18.

(4) Designee--An entity to which HHSC has delegated certain functions for provider enrollment purposes. A designee may include:

(A) an HHSC contractor;

(B) a health and human services agency; or

(C) a managed care organization (MCO) that contracts with HHSC under Medicaid or CHIP.

(5) Disenroll--To end a provider's participation in Medicaid or CHIP before the end of the provider's current enrollment period.

(6) Enrollment--The process for applying to become a provider, including contracting and procedures for determining whether to grant approval to enter into a provider agreement.

(7) Enrollment application--Documentation required by HHSC that an applicant submits to HHSC to enroll or re-enroll as a provider or to add a new practice location. An enrollment application includes supplemental forms used to add practice locations for Medicare-enrolled or limited-risk providers, as determined by HHSC.

(8) Enrollment type--A type of enrollment category that identifies how the applicant seeks to enroll, such as individual, group, performing provider, or facility.

(9) Entity--A provider group, a facility, an organization, or a business registered with the Texas Secretary of State.

(10) Health care practitioner--A physician or non-physician licensed or certified health care provider who is recognized by federal law or by HHSC as a provider who can bill for medical services or benefits, submits orders or referrals for services to treat, certifies medical need for services, or supervises other individuals providing services and benefits to Medicaid or CHIP recipients.

(11) Health and human services agency--A state agency identified in Texas Government Code §521.0001(5) [§~~531.001(4) of the Government Code~~].

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

(13) Medicaid--The medical assistance program, a state and federal cooperative program authorized under Title XIX of the Social Security Act that pays for certain medical and health care costs for people who qualify.

(14) National Provider Identifier--A unique ten-digit identification number assigned by the Centers for Medicare & Medicaid Services.

(15) Overpayment--A payment made to a provider in excess of the amount that is allowable for the service provided, plus any accrued interest.

(16) Person with an ownership or control interest--Has the meaning assigned by §371.1003 of this title (relating to Definitions).

(17) Provider--An applicant that successfully completes the enrollment process outlined in this chapter and in Chapter 371 of this title (relating to Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity).

(18) Provider agreement--An agreement between HHSC and a provider wherein the provider agrees to certain contract provisions as a condition of participation.

(19) Re-enrolling provider--A provider that submits an enrollment application before the end of the provider's current enrollment period.

(20) Recipient--A person receiving benefits under Medicaid or CHIP.

(21) Surety bond--One or more bonds issued by one or more surety companies under 31 U.S.C. §§9304 - 9308 and 31 CFR parts 223, 224, and 225.

(22) Terminate--To take an adverse action against a provider whose participation in Medicaid or CHIP has ended at federal or state agency direction due to violation of state rules or federal regulations.

(23) Third-party billing vendor--A vendor registered with HHSC or its designee that submits claims for reimbursement on behalf of a provider.

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 353. MEDICAID MANAGED CARE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §353.8, concerning Certification of Managed Care Organizations Prior to Contract Awards; §353.101, concerning Purpose; §353.201, concerning Purpose; §353.407, concerning Requirements of Managed Care Plans; §353.425, MCO Processing of Prior Authorization Requests Received with Incomplete or Insufficient Documentation; §353.427, Accessibility of Information Regarding Medicaid Prior Authorization Requirements; §353.501, concerning Purpose; §353.901, concerning Purpose; §353.905, concerning Managed Care Organization Requirements; §353.1153, concerning STAR+PLUS Home and Community Based Services (HCBS) Program; §353.1155, concerning Medically Dependent Children Program; and §353.1451, concerning Purpose and Authority.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

Trey Wood, HHSC Chief Financial Services 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 not create a new regulation;

(6) the proposed rules will not expand, limit, or 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.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules because the amendments only update references to existing laws.

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

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social 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 amendments only update references to existing laws.

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 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 24R084" in the subject line.

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §353.8

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 Chapters 523, 526, 540, and 544.

The amendments affect Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.8. Certification of Managed Care Organizations Prior to Contract Awards.

(a) As provided by Texas Government Code §540.0203 [~~§533.0035 of the Texas Government Code~~], the Texas Health and Human Services Commission (HHSC) awards a contract under [~~Chapter 533 of the~~] Texas Government Code Chapter 540 to a managed care organization (MCO) only if the MCO has been certified by HHSC as reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law.

(b) HHSC determines whether to certify an MCO following the evaluation of the proposals submitted in response to a solicitation. Certification and the certification determination process described in this section do not impact an MCO's final score in the evaluation, but failure to obtain certification results in no further consideration of the MCO for the contract award.

(c) In its certification determination, HHSC may review:

(1) materials submitted by the MCO in response to the solicitation;

(2) materials related to the MCO's past performance in any state, including materials required to be monitored by a state's managed care program under 42 C.F.R. §438.66(c); and

(3) any additional information and assurances requested by HHSC from the MCO for purposes of the certification determination.

(d) HHSC provides notice of approval or denial of certification by electronic mail to an MCO. A notice of denial sets forth the reasons for the denial of certification. If an MCO is denied certification, the MCO may appeal the denial by submitting an appeal to the solicitation's sole point of contact no later than 10 business days after the date HHSC transmits the notice of denial of certification.

(e) An appeal must specifically address the reasons for the denial of the certification as stated in the notice of denial and precisely state the argument, authorities, and evidence the MCO offers in support of its appeal.

(f) To resolve an appeal, HHSC:

(1) dismisses the appeal as untimely;

(2) upholds the denial of certification; or

(3) reverses the denial of certification and certifies the MCO as reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law.

(g) After the expiration of the appeal period and the resolution of any pending appeals, MCOs that obtained the required certification will proceed to the next phase of the contract award process.

(h) HHSC's determination whether to certify that an MCO is reasonably able to fulfill the terms of a contract is not a contested case proceeding under the Texas Administrative Procedure Act, Texas Government Code, Chapter 2001.

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 B. PROVIDER AND MEMBER EDUCATION PROGRAMS

1 TAC §353.101

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 Chapters 523, 526, 540, and 544.

The amendment affects Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.101. Purpose.

This subchapter implements the Health and Human Services Commission's authority to establish provider and member education requirements for managed care organizations participating in the Texas Medicaid program. This authority is granted in Texas Government Code §540.0054 [~~§531.0211~~].

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SUBCHAPTER C. MEMBER BILL OF RIGHTS AND RESPONSIBILITIES

1 TAC §353.201

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 Chapters 523, 526, 540, and 544.

The amendment affects Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.201. Purpose.

This subchapter implements the Health and Human Services Commission's authority to adopt a member bill of rights and responsibilities. This authority is granted in Texas Government Code §532.0301 [~~§531.0212~~].

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SUBCHAPTER E. STANDARDS FOR MEDICAID MANAGED CARE

1 TAC §§353.407, 353.425, 353.427

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 Chapters 523, 526, 540, and 544.

The amendments affect Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.407. Requirements of Managed Care Plans.

(a) Entities or individuals who subcontract with an MCO to provide benefits, perform services, or carry out any essential function of the MCO contract must meet the same qualifications and contract requirements as the MCO for the service, benefit, or function delegated under the subcontract.

(b) An MCO must reimburse a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or a municipal health department's public clinic for health care services provided to a member outside of regular business hours, as defined at §353.2 of this title (relating to Definitions), at a rate that is equal to the allowable rate for those services as determined under §32.028(e) and (f), Human Resources Code, if the member does not have a referral from the member's primary care provider.

(c) An MCO must comply with HHSC's policy on contracting and subcontracting with historically underutilized businesses (HUBs). HHSC's policy is to meet the goals and good faith effort requirements as stated in the Comptroller of Public Accounts rules at 34 TAC Chapter 20, Subchapter B (relating to Historically Underutilized Business Program).

(d) An MCO must contract with advance practice registered nurses and physician assistants as primary care providers in compliance with Texas Government Code §540.0269 [~~§533.005(a)(13)~~].

(e) Beginning March 1, 2015, an MCO must provide Medicaid benefits to nursing facility residents and reimburse nursing facility providers in compliance with Texas Government Code §540.0752(b) [~~§533.00251(c)~~].

§353.425. MCO Processing of Prior Authorization Requests Received with Incomplete or Insufficient Documentation.

(a) The rules in this section apply when a prior authorization (PA) request is submitted with incomplete or insufficient information or documentation on behalf of a member who is not hospitalized at the time of the request.

(b) In this section, "incomplete PA request" means a request for service that is missing information or documentation necessary to establish medical necessity as listed in the PA requirements on the managed care organization's (MCO's) website.

(c) An MCO must comply with Title 42 Code of Federal Regulations §438.210, applicable provisions of Texas Government Code Chapter 540 [~~533~~], and the PA process and timeline requirements included in an MCO's contract with the Texas Health and Human Services Commission (HHSC).

(d) If an MCO or an entity reviewing a request on behalf of an MCO receives a PA request with incomplete or insufficient information or documentation, the MCO or reviewing entity must comply with the following HHSC requirements.

(1) An MCO reviewing the request must notify the requesting provider and the member, in writing, of the missing information no later than three business days after the MCO receives an incomplete PA request.

(2) If an MCO does not receive the information requested within three business days after the MCO notifies the requesting provider and the PA request will result in an adverse benefit determination, the MCO must refer the PA request to the MCO medical director for review.

(3) The MCO must offer to the requesting physician an opportunity for a peer-to-peer consultation with a physician no less than one business day before the MCO issues an adverse benefit determination.

(4) The MCO must make a final determination as expeditiously as the member's condition requires but no later than three business days after the date the missing information is provided to an MCO.

(e) The HHSC requirements for MCO reconsideration of an incomplete PA request do not affect any related timeline for:

(1) an MCO's internal appeal process;

(2) a Medicaid state fair hearing;

(3) a review conducted by an external medical reviewer; or

(4) any rights of a member to appeal a determination on a PA request.

§353.427. Accessibility of Information Regarding Medicaid Prior Authorization Requirements.

(a) In this section, "accessible" means publicly available and capable of being found and read without impediment. Usernames and passwords cannot be required to view the information.

(b) A managed care organization (MCO) must maintain on its public-facing website the MCO's criteria and policy for prior authorizations and website links to any prior authorization request forms the provider uses.

(c) The MCO must maintain the following items on its website in an easily searchable and accessible format.

(1) Applicable timelines for prior authorization requirements, including:

(A) the timeframe in which the MCO must make a determination on a prior authorization request;

(B) a description of the notice the MCO provides to a provider or member regarding the documentation required to complete a prior authorization determination; and

(C) the deadline by which the MCO must submit the notice described in subparagraph (B) of this paragraph.

(2) An accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) the effective date of a prior authorization requirement, if the requirement is first imposed on or after September 1, 2019;

(B) a list or description of any supporting or supplemental documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each annual review of the MCO's prior authorization requirements as required by Texas Government Code §540.0304 [~~§533.00283(a)~~].

(3) The process and contact information for a provider or member to contact the MCO to:

(A) clarify prior authorization requirements; and

(B) obtain assistance in submitting a prior authorization request.

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SUBCHAPTER F. SPECIAL INVESTIGATIVE UNITS

1 TAC §353.501

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 Chapters 523, 526, 540, and 544.

The amendment affects Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.501. Purpose.

(a) This subchapter implements the Health and Human Services Commission's (HHSC), Office of Inspector General (OIG) authority to approve annually, each managed care organization (MCO) plan to prevent and reduce waste, abuse, and fraud. This authority is granted by Texas Government Code §544.0352 [~~Chapter 531, Subchapter C, Government Code, §531.113~~].

(b) An MCO that provides or arranges for the provision of health care services or dental services to an individual under the Medical Assistance Program (Medicaid), must arrange for a special investigative unit to investigate fraudulent claims and other types of program abuse by recipients and providers. An MCO may choose to:

(1) establish and maintain the special investigative unit within the MCO; or

(2) contract with another entity for the investigation.

(c) An MCO must:

(1) develop a plan to prevent and reduce waste, abuse, and fraud;

(2) submit the plan annually to the HHSC-OIG for approval each year the MCO is enrolled with the State of Texas; and

(3) submit the plan 90 days before the start of the State fiscal year.

(d) If HHSC-OIG does not approve the initial plan to prevent and reduce waste, abuse, and fraud, the MCO must resubmit the plan to HHSC-OIG within 15 working days of receiving the denial letter, which will explain the deficiencies. If the plan is not resubmitted within the time allotted, the MCO will be in default and remedies or sanctions may be imposed.

(e) If the MCO elects to contract with another entity for the investigation of fraudulent claims and other types of program abuse as referenced in subsection (b)(2) of this section, the MCO must comply with all requirements of Title 42, §438.230 of the Code of Federal Regulations.

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SUBCHAPTER J. OUTPATIENT PHARMACY SERVICES

1 TAC §353.901, §353.905

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 Chapters 523, 526, 540, and 544.

The amendments affect Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.901. Purpose.

The purpose of this subchapter is to implement the requirements of Texas Government Code §540.0273 [~~§533.005~~], which establishes requirements for providing outpatient pharmacy benefits through Medicaid managed care. This subchapter applies to health care managed care organizations.

§353.905. Managed Care Organization Requirements.

(a) A health care managed care organization (health care MCO) must adopt and exclusively use the Health and Human Services Commission's (HHSC's) Medicaid formulary and preferred drug list.

(b) A health care MCO is not authorized to negotiate rebates for covered outpatient drugs with drug manufacturers, or to receive confidential drug pricing regarding covered outpatient drugs from drug manufacturers.

(c) A health care MCO cannot pay claims submitted by a pharmacy provider who is under sanction or exclusion from the Medicaid or CHIP Programs.

(d) Except as provided in subsection (e) of this section, a health care MCO must enter into a network provider agreement with any pharmacy provider that meets the health care MCO's credentialing requirements, and agrees to the health care MCO's financial terms and other reasonable administrative and professional terms.

(e) A health care MCO can enter into selective pharmacy provider agreements for specialty drugs, as defined in §354.1853 of this title (relating to Specialty Drugs), subject to the following limitations:

(1) A health care MCO is prohibited from entering into an exclusive contract for specialty drugs with a pharmacy owned in full or part by a pharmacy benefits manager contracted with the health care MCO.

(2) The selective contracting agreement cannot require the pharmacy provider to contract exclusively with the health care MCO.

(3) A health care MCO cannot require a member to obtain a specialty drug from a mail-order pharmacy.

(f) A health care MCO must allow pharmacy providers to fill prescriptions for covered outpatient drugs ordered by any licensed prescriber regardless of the prescriber's network participation.

(g) A health care MCO must pay claims in accordance with Texas Insurance Code §843.339, relating to prescription drug claims payment requirements.

(h) A health care MCO must comply with Texas Government Code §540.0273 [~~§533.005(a)(23), (a-1), and (a-2) of the Government Code~~] related to outpatient pharmacy benefit requirements in Medicaid managed care.

(i) A health care MCO must comply with the rules in Chapter 354, Subchapter F (relating to Pharmacy Services) of this title with the exception of:

(1) Section 354.1867 (relating to Refills);

(2) Section 354.1873 (relating to Freedom of Choice);

(3) Section 354.1877 (relating to Quantity Limitations); and

(4) Division 6 (relating to Pharmacy Claims).

(j) A health care MCO must require its subcontractors to comply with the requirements of this subchapter when providing outpatient pharmacy benefits through Medicaid managed care.

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SUBCHAPTER M. HOME AND COMMUNITY BASED SERVICES IN MANAGED CARE

1 TAC §353.1153, §353.1155

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 Chapters 523, 526, 540, and 544.

The amendments affect Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

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

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

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

(A) be 21 years of age or older;

(B) reside in Texas;

(C) meet the level-of-care criteria for medical necessity for nursing facility care as determined by HHSC;

(D) have an unmet need for support in the community that can be met through one or more of the STAR+PLUS HCBS program services;

(E) choose the STAR+PLUS HCBS program as an alternative to nursing facility services, as described in 42 CFR §441.302(d);

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

(G) be determined by HHSC to be financially eligible for Medicaid, as described in Chapter 358 of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities) and Chapter 360 of this title (relating to Medicaid Buy-In Program).

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

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

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

(A) calling HHSC toll-free at 1-855-937-2372;

(B) submitting a written request to HHSC; or

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

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

(A) the individual is deceased;

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

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

(D) the individual is no longer a Texas resident, unless the individual is a military family member living outside of Texas as described in Texas Government Code §526.0602 [~~§531.0931~~]:

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

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

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

(1) The ISP must:

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

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

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

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

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

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

(G) be approved by HHSC; and

(H) be cost effective.

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

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

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

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

(g) HHSC conducts utilization reviews of STAR+PLUS MCOs as described in Texas Government Code §540.0755 [~~§533.00281~~].

§353.1155. Medically Dependent Children Program.

(a) An MCO assesses an individual's eligibility for MDCP.

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

(A) be under 21 years of age;

(B) reside in Texas;

(C) meet the level of care criteria for medical necessity for nursing facility care as determined by HHSC;

(D) have an unmet need for support in the community that can be met through one or more MDCP services;

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

(F) not be enrolled in one of the following Medicaid HCBS waiver programs approved by CMS:

(i) the Community Living Assistance and Support Services (CLASS) Program;

(ii) the Deaf Blind with Multiple Disabilities (DBMD) Program;

(iii) the Home and Community-based Services (HCS) Program;

(iv) the Texas Home Living (TxHmL) Program; or

(v) the Youth Empowerment Services waiver;

(G) live in:

(i) the individual's home; or

(ii) an agency foster home as defined in Texas Human Resource Code, §42.002, (relating to Definitions); and

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

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

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

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

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

(B) submitting a written request to HHSC; or

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

(2) If a request is made in accordance with paragraph (1) of this subsection, HHSC adds an individual's name to the MDCP interest list:

(A) if the individual is a Texas resident; and

(B) using the date HHSC receives the request as the MDCP interest list date.

(3) For an individual determined diagnostically or functionally ineligible during the enrollment process for the CLASS Program, DBMD Program, HCS Program, or TxHmL Program:

(A) if the individual's name is not on the MDCP interest list, at the request of the individual or LAR, HHSC adds the individual's name to the MDCP interest list using the individual's interest list date for the waiver program for which the individual was determined ineligible as the MDCP interest list date;

(B) if the individual's name is on the MDCP interest list and the individual's interest list date for the waiver program for which the individual was determined ineligible is earlier than the individual's MDCP interest list date, at the request of the individual or LAR, HHSC changes the individual's MDCP interest list date to the individual's interest list date for the waiver program for which the individual was determined ineligible; or

(C) if the individual's name is on the MDCP interest list and the individual's MDCP interest list date is earlier than the individual's interest list date for the waiver program for which the individual was determined ineligible, HHSC does not change the individual's MDCP interest list date.

(4) This paragraph applies to an individual who is enrolled in MDCP and, because the individual does not meet the level of care criteria for medical necessity for nursing facility care, is determined ineligible for MDCP after November 30, 2019. The individual or the individual's LAR may request one time that HHSC add the individual's name to the first position on the MDCP interest list.

(5) This paragraph applies to an individual who is enrolled in MDCP and, because the individual does not meet the level of care criteria for medical necessity for nursing facility care or the requirement to be under 21 years of age, is determined ineligible for MDCP after November 30, 2019. The individual or the individual's LAR may request that HHSC add the individual's name to the interest list for any of the following programs or change the individual's interest list date for any of the following programs in accordance with:

(A) 40 TAC §45.202 (relating to CLASS Interest List) for the CLASS Program;

(B) 40 TAC §42.202 (relating to DBMD Interest List) for the DBMD Program;

(C) 40 TAC §9.157 (relating to HCS Interest List) for the HCS Program; and

(D) 40 TAC §9.566 (relating to TxHmL Interest List) for the TxHmL Program.

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

(A) the individual is deceased;

(B) the individual is assessed for MDCP and determined to be ineligible and has had an opportunity to exercise the individual's right to a fair hearing, as described in Chapter 357 of this title (relating to Hearings);

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

(D) the individual moves out of Texas, unless the individual is a military family member living outside of Texas as described in Texas Government Code §526.0602 [~~§531.0931~~]:

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

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

(7) An individual assessed for MCDP and determined to be ineligible, as described in paragraph (6)(B) of this subsection, may request to have the individual's name added to the MDCP interest list as described in paragraph (1) of this subsection.

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

(1) An ISP must:

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

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

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

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

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

(F) be reviewed and revised if the member's needs or natural supports change or at the request of the member or LAR; and

(G) be cost effective.

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

(d) An MCO is responsible for conducting a reassessment and developing an ISP for each member's continued eligibility for MDCP, in accordance with the policies and procedures outlined in the STAR Kids Handbook, UMCM, or materials designated by HHSC and in accordance with the timeframes outlined in the MCO's contract.

(e) An MCO is responsible for authorizing a provider of a member's choice to deliver services outlined in the member's ISP.

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

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

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

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405187
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 221-9021

SUBCHAPTER Q. PROCESS TO RECOUP CERTAIN OVERPAYMENTS

1 TAC §353.1451

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 Chapters 523, 526, 540, and 544.

The amendment affects Texas Government Code §531.0055 and Chapters 523, 526, 540, and 544.

§353.1451. Purpose and Authority.

The purpose of this subchapter is to describe the due process a managed care organization (MCO) must give to recoup an overpayment related to an electronic visit verification visit transaction in accordance with Texas Government Code §544.0503 [~~, §531.1135~~] and the due process an MCO must give to recoup an overpayment related to a determination of fraud or abuse in accordance with Texas Government Code §544.0502 [~~, §531.1131~~].

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 October 31, 2024.

TRD-202405188
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 221-9021

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SUBCHAPTER O. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

1 TAC §353.1309

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1309, concerning Texas Incentives for Physicians and Professional Services.

BACKGROUND AND PURPOSE

The purpose of the proposal is to make modifications to the Texas Incentives for Physicians and Professional Services (TIPPS) program to provide additional details concerning the pay-for-performance model established for Component Two of the program, beginning in State Fiscal Year (SFY) 2026. The rule amendment changes how certain TIPPS funds will be redistributed to other physician groups participating in TIPPS if a physician group fails to earn those funds due to a failure to achieve performance requirements for Component Two of TIPPS.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services (CMS) to create TIPPS as part of the financial and quality transition from the Delivery System Reform Incentive Payment (DSRIP) program. Directed payment programs authorized under 42 Code of Federal Regulations (C.F.R.) §438.6(c), including TIPPS, are expected to continue to evolve over time to advance quality goals or objectives the program is intended to impact. HHSC previously amended the TIPPS rule to shift the program structure in SFY 2026 to provide that Component Two will be paid to physician groups based on a pay-for-performance model using achievement of quality measures and paid through a scorecard. Health Related Institution (HRI) and Indirect Medical Education (IME) physician groups are eligible for Component Two payments.

Under this rule amendment, if a physician group does not meet the performance requirements for Component Two, the funds that are not earned by that physician group will be redistributed among other physician groups in the same Service Delivery Area (SDA) and class (HRI or IME), based on how much those physician groups have already earned for Component Two. If no physician group in the same SDA and class earned funds under Component 2, the funds will be distributed across all physician groups in that SDA, based on how much those physician groups have already earned for Component Two. If there are no physician groups in that SDA that earned Component Two funds, the unearned funds will be distributed across all HRI and IME physician groups participating in TIPPS, based on how much those physician groups have already earned for Component Two. Multiple providers have requested that HHSC make the changes being proposed to allow redistribution of unearned funds back to providers. HHSC is interested in stakeholder feedback on the proposed redistribution of unearned funds in TIPPS.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1309(h)(1)(B)(iii) proposes the redistribution of funds available under Component 2 of TIPPS that is not earned by a physician group due to a failure to achieve performance requirements and provides the calculation method for redistribution. The redistribution varies depending on the location and class of physician group that earn funds under Component 2 of TIPPS.

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 government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

Trey Wood, Chief Financial Officer, has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities to comply with the proposed rule because participation in the program is voluntary.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of the Provider Finance Department, has determined that for each year of the first five years the rule is in effect, the public will benefit from the proposed rule. It will increase the funding available directly for physician groups under the TIPPS program, which could encourage more physician groups to continue program participation. Increased participation would then increase the overall public dollars available in the program.

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 participation in the program is optional.

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 HEARING

A public hearing is scheduled for December 3, 2024, at 9:00 a.m. (Central Standard Time) to receive public comments on the proposal via webinar. Persons requiring further information, special assistance, or accommodations should email pfd_tipps@hhs.texas.gov.

Persons interested in attending may register for the public hearing at:

https://attendee.gotowebinar.com/register/3035089041097014111

After registering, a confirmation email will be sent with information about joining the webinar.

HHSC will broadcast the public hearing. The broadcast will be archived for access on demand and can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Acute Care Services, Mail Code H-400 at 4601 W. Guadalupe St. Austin, Texas 78751 or via email at pfd_tipps@hhs.texas.gov.

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R007" in the subject line.

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 Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; 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, Texas Government Code Chapter 533, and Texas Human Resources Code Chapter 32.

§353.1309. Texas Incentives for Physicians and Professional Services.

(a) Introduction. This section establishes the Texas Incentives for Physicians and Professional Services (TIPPS) program. TIPPS is designed to incentivize physicians and certain medical professionals to improve quality, access, and innovation in the provision of medical services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1311 of this subchapter (relating to Quality Metrics for the Texas Incentives for Physicians and Professional Services Program).

(1) Health Related Institution (HRI) physician group--A network physician group owned or operated by an institution named in Texas Education Code §63.002.

(2) Indirect Medical Education (IME) physician group--A network physician group contracted with, owned, or operated by a hospital receiving either a medical education add-on or a teaching medical education add-on as described in §355.8052 of this title (relating to Inpatient Hospital Reimbursement) for which the hospital is assigned or retains billing rights for the physician group.

(3) Intergovernmental Transfer (IGT) Notification--Notice and directions regarding how and when IGTs should be made in support of the program.

(4) Network physician group--A physician group located in the state of Texas that has a contract with a Managed Care Organization (MCO) for the delivery of Medicaid-covered benefits to the MCO's enrollees.

(5) Network status--A provider's network status with a contracted MCO, as determined by the national provider identification (NPI) number and Plan Code combination.

(6) Other physician group--A network physician group other than those specified under paragraphs (1) and (2) of this subsection.

(7) Plan code--A unique 2-digit alphanumeric code established by HHSC denoting the individual managed care organization, program, and service delivery area.

(8) Program period--A period of time for which an eligible and enrolled physician group may receive the TIPPS amounts described in this section. Each TIPPS program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(9) Suggested IGT responsibility--Notice of potential amounts that a governmental entity may wish to consider transferring in support of the program.

(10) Total program value--The maximum amount available under the TIPPS program for a program period, as determined by HHSC.

(c) Eligibility for participation in TIPPS. A physician group is eligible to participate in TIPPS if it complies with the requirements described in this subsection.

(1) Physician group composition. A physician group must indicate the eligible physicians, clinics, and other locations to be considered for payment and quality measurement purposes in the application process.

(2) Minimum volume. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, physician groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 50 percent of the quality metrics in each component to be eligible to participate in the component. For

program periods beginning on or after September 1, 2024, no minimum denominator volume is required.

(3) The physician group is:

(A) an HRI physician group;

(B) an IME physician group; or

(C) any other physician group that:

(i) can achieve the minimum volume during program periods beginning on or before September 1, 2023, but on or after September 1, 2021, as described in paragraph (2) of this subsection;

(ii) is located in a service delivery area with at least one sponsoring governmental entity; and

(iii) for program periods beginning on or before September 1, 2023, but on or after September 1, 2021, served at least 250 unique Medicaid managed care clients in the prior state fiscal year. For program periods beginning on or after September 1, 2024, no minimum volume is required.

(d) Data sources for historical units of service and clients served. Historical units of service are used to determine a physician group's eligibility status and the estimated distribution of TIPPS funds across enrolled physician groups.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's NPI number and taxonomy code combination that are billed as a professional encounter only.

(2) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine the eligibility status of other physician groups for program periods beginning on or before September 1, 2023, but on or after September 1, 2021.

(3) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine distribution of TIPPS funds across eligible and enrolled physician groups.

(4) In the event of a disaster, HHSC may use data from a different state fiscal year at HHSC's discretion.

(5) The data used to estimate eligibility and distribution of funds will align with the data used for purposes of setting the capitated rates for managed care organizations for the same period.

(6) HHSC will calculate the estimated rate that an average commercial payor would have paid for the same services using either data that HHSC obtains independently or data that is collected from providers through the application process described in subsection (c) of this section.

(7) If HHSC is unable to compute an actuarially sound payment rate based on private payor information described in paragraph (6) of this subsection for any services, then those services will be removed from consideration from the TIPPS program.

(8) All services billed and delivered at a Federally Qualified Health Center, dental services, and ambulance services are excluded from the scope of the TIPPS program.

(9) Encounter data used to calculate payments for this program must be designated as paid status. Encounters reported as a paid status, but with zero or negative dollars as a reported paid amount will not be included in the data used to calculate payments for the TIPPS program.

(10) If a provider with the same Tax Identification Number as the payor is being paid more than 200 percent of the Medicaid reimbursement on average for the same services in a one-year period, then a related-party-adjustment will be applied to the encounter data for those encounters. This adjustment will apply a calculated average payment rate from the rest of the provider pool to the related parties paid units of service.

(e) Conditions of Participation. As a condition of participation, all physician groups participating in TIPPS must allow for the following.

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

(2) Enrollment is conducted annually, and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the suggested IGT responsibilities under subsection (f)(1) of this section. For each program period, a physician group must be located in a Service Delivery Area (SDA) in which at least one sponsoring governmental entity that agrees to transfer to HHSC some or all of the non-federal share under this section is also located. An SDA is designated by HHSC for each provider, or physician group with multiple locations, based on the SDA in which the majority of a physician group's claims are billed. Services that are provided outside of a designated SDA may be included in the designated SDA.

(3) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(4) The entity that bills on behalf of the physician group must certify, on a form prescribed by HHSC, that no part of any TIPPS payment will be used to pay a contingent fee nor may the entity's agreement with the physician group use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the physician group's receipt of TIPPS funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(5) If a provider has changed ownership in the past five years in a way that impacts eligibility for the TIPPS 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, the TIPPS program.

(6) Report all quality data denoted as required as a condition of participation in §353.1311(d)(1) of this subchapter.

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

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

(1) HHSC will communicate suggested IGT responsibilities for the program period with all TIPPS eligible and enrolled HRI physician groups and IME physician groups at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under the TIPPS program for the program period as determined by HHSC, plus

eight percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across HRI physician groups and IME physician groups, plus estimated utilization for eligible and enrolled other physician groups within the same service delivery area, for the program period. HHSC will also communicate the estimated maximum revenues each eligible and enrolled physician group could earn under TIPPS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled physician groups will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 21 business days before the first half of the IGT amount is transferred to HHSC.

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

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

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

(4) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) TIPPS capitation rate components. TIPPS funds will be paid to Managed Care Organizations (MCOs) through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of TIPPS funds to the enrolled physician groups will be based on each physician group's performance related to the quality metrics as described in §353.1311 of this subchapter. The physician group must have provided at least one Medicaid service to a Medicaid client in each reporting period to be eligible for payments.

(1) Component One.

(A) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the total value of Component One will be equal to 65 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based on historical Medicaid clients served.

(ii) Monthly payments to HRI and IME physician groups will be a uniform rate increase.

(iii) Other physician groups are not eligible for payments from Component One.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) HHSC will reconcile the interim allocation of funds across qualifying HRI and IME physician groups to the actual distribution of Medicaid clients served across these physician groups during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(vi) Redistribution resulting from the reconciliation will be based on the actual utilization of enrolled NPIs.

(vii) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(B) For the program period beginning on September 1, 2024, the total value of Component One will be equal to 90 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase paid at the time of claim adjudication.

(iii) Other physician groups are not eligible for payments from Component One.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(C) For program periods beginning on or after September 1, 2025, the total value of component one will be equal to 55 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase paid at the time of claim adjudication.

(iii) Other physician groups are not eligible for payments from Component One.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the total value of Component Two will be equal to 25 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase.

(iii) Other physician groups are not eligible for payments from Component Two.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) HHSC will reconcile the interim allocation of funds across qualifying HRI and IME physician groups to the actual distribution of Medicaid clients served across these physician groups

during the program period as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(vi) Redistribution resulting from the reconciliation will be based on the actual utilization of enrolled NPIs.

(vii) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(B) For the program period beginning September 1, 2024, Component Two will be equal to 0 percent of the program.

(C) For program periods beginning on or after September 1, 2025, the total value of Component Two will be equal to 35 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be made through a pay-for-performance model based on their achievement of quality measures and paid through a scorecard.

(iii) Other physician groups are not eligible for payments from Component Two.

(3) Component Three.

(A) The total value of Component Three will be equal to 10 percent of the total program value.

(B) Allocation of funds across physician groups will be proportional, based upon actual Medicaid utilization of specific procedure codes as identified in the final quality metrics or performance requirements described in §353.1311 of this subchapter.

(C) Payments to physician groups will be a uniform rate increase.

(D) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(h) Distribution of TIPPS payments.

(1) Before the beginning of the program period, HHSC will calculate the portion of each PMPM associated with each TIPPS enrolled practice group broken down by TIPPS capitation rate component and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs and the MCO network status at the time of the application under subsection (e)(1) of this section. For example, for a physician group, HHSC will calculate the portion of each PMPM associated with that group that would be paid from the MCO to the physician group as follows.

(A) Payments from Component One.

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, payments will be monthly and will be equal to the total value of Component One for the physician group divided by twelve.

(ii) For program periods beginning on or after September 1, 2024, payments will be made as a uniform percentage increase paid at the time of claim adjudication.

(B) Payments from Component Two.

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, payments will be semi-annual and will be equal to the total value of Component Two for the physician group divided by 2.

(ii) For the program period beginning on September 1, 2024, no payments will be made for Component Two.

(iii) For program periods beginning on or after September 1, 2025, payment will be made on a scorecard basis at payments based on the reporting of quality measures and paid through a scorecard at the time of achievement. Funds that are not earned by a physician group due to failure to achieve performance requirements will be redistributed to other physician groups in the same SDA and physician group class (HRI or IME) based on each physician group's proportion of total earned Component Two funds in the SDA. If no other physician group in the SDA and physician group class receives performance payments, unearned funds will be redistributed to all HRI or IME physician groups in the SDA based on each physician group's proportion of total earned Component Two funds. If no physician group in the SDA receives performance payments, unearned funds will be redistributed to all HRI and IME physician groups participating in TIPPS based on each physician group's proportion of total earned Component Two funds.

(C) Payments from Component Three will be equal to the total value of Component Three attributed as a uniform rate increase based upon historical utilization.

(2) MCOs will distribute payments to enrolled physician groups as directed by HHSC. Payments will be equal to the portion of the TIPPS PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the TIPPS PMPM.

(i) Changes in operation. If an enrolled physician group closes voluntarily or ceases to provide Medicaid services, the physician group 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 Medicaid 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 each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

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

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (737) 230-0550

CHAPTER 354. MEDICAID HEALTH SERVICES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1189, concerning Acute Care Medicaid Billing Coordination System; §354.1435, concerning Provision of Behavioral Health Services through an Audio-Only Platform; §354.1924, concerning Preferred Drug List; §354.1941, concerning Drug Utilization Review Board; §354.2501, concerning Definitions; §354.2603, concerning Definitions; §354.3001, concerning Purpose and Applicability; §354.4001, concerning Purpose and Authority; §354.4003, concerning Definitions; and §354.5011, concerning Providers of Applied Behavior Analysis (ABA) Services.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

Trey Wood, HHSC Chief Financial Services 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 not create a new regulation;

(6) the proposed rules will not expand, limit, or 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.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules because the amendments only update references to existing laws.

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

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social 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 amendments only update references to existing laws.

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 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 24R084" in the subject line.

SUBCHAPTER A. PURCHASED HEALTH SERVICES

DIVISION 11. GENERAL ADMINISTRATION

1 TAC §354.1189

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.1189. Acute Care Medicaid Billing Coordination System.

An acute care Medicaid billing coordination system is mandated by Texas Government Code §532.0058 [~~the Government Code §531.02413~~]. The Health and Human Services Commission (HHSC)

will develop and implement an acute care Medicaid billing coordination system for the fee-for-service delivery model that identifies whether another entity has primary payor responsibility.

(1) An entity holding a permit, license, or certificate of authority issued by a state regulatory agency must allow HHSC or its designee to access databases that enable it to carry out the purposes of this section. Entities subject to this section are those entities that are, by statute, contract or agreement, legally responsible for the payment of a claim for a health care item or service.

(2) HHSC shall refer any entity that violates this rule to the regulatory agency issuing the permit, license, or certificate of authority for possible administrative sanction.

(3) After September 1, 2008, no public funds shall be expended on entities not in compliance with this section unless a memorandum of understanding is entered into between the entity and HHSC.

(4) Information obtained under this section must be secure and maintain the confidentiality of the client's health records in compliance with security and privacy rules adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. §§164.302 - 164.318 and §§164.500 - 164.534.

(5) The administrator of the acute care Medicaid billing coordination system shall be determined by HHSC. The administrator shall be responsible for meeting all requirements of the acute care Medicaid billing coordination system.

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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DIVISION 33. ADVANCED TELECOMMUNICATIONS SERVICES

1 TAC §354.1435

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.1435. Provision of Behavioral Health Services through an Audio-Only Platform.

The Texas Health and Human Services Commission (HHSC) recognizes that mental health services are expressly excluded from the provisions of Texas Occupations Code Chapter 111 and further, that the term "mental health services" is not defined in Texas Occupations Code Chapter 111. Additionally, HHSC recognizes the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and the National Institute of Mental Health recognize substance use disorder as a mental disorder. Acknowledging the importance of access to substance use disorder and pursuant to HHSC's broad rulemaking authority in Texas Government Code §524.0005 and §524.0151 [~~§531.0055 and §531.033~~] and Texas Human Resources Code §32.021, for the purposes of this rule, HHSC considers the provision of mental health services, as that term is used in Texas Occupations Code Chapter 111, to be synonymous with the provision of behavioral health services. Conditions for reimbursement applicable to behavioral health services provided through an audio-only platform are described in this section.

(1) The provider must be enrolled in Texas Medicaid.

(2) The provider must obtain informed consent from the client, client's parent, or the client's legally authorized representative prior to rendering a behavioral health service via an audio-only platform; except when doing so is not feasible or could result in death or injury to the client. Verbal consent is permissible and must be documented in the client's medical record.

(3) The covered services must be provided in compliance with the standards established by the respective licensing or certifying board of the professional providing the audio-only telemedicine medical service or audio-only telehealth service.

(4) Behavioral health services provided via audio-only platform must be designated for reimbursement by HHSC. Behavioral health services provided via an audio-only platform designated for reimbursement are those that are clinically effective and cost-effective, as determined by HHSC and in accordance with §354.1432(3) of this subchapter (relating to Telemedicine and Telehealth Benefits and Limitations). Behavioral health services that HHSC has determined are clinically effective and cost-effective when provided via an audio-only platform can be found in the Texas Medicaid Provider Procedures Manual (TMPPM).

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. PHARMACY SERVICES

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

1 TAC §354.1924

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.1924. Preferred Drug List.

(a) Purpose. This section implements the provisions of Texas Government Code §549.0202 [~~§531.072, Government Code~~], which directs the Health and Human Services Commission (HHSC) to develop and implement a preferred drug list (PDL) for the Texas Medical Assistance Program.

(b) Applicability. This section applies to drugs included in the Texas Drug Code Index (TDCI) established under §354.1921 of this title (relating to Addition of Drugs to the Texas Drug Code Index).

(c) Selection of drugs for the PDL. HHSC will include a drug listed on the TDCI in the PDL on the basis of:

(1) The recommendations of the Drug Utilization Review Board (DUR Board) established under §354.1941 of this subchapter (relating to Drug Utilization Review Board);

(2) The clinical efficacy of the drug, consistent with the determination of the Food and Drug Administration and the recommendations of the DUR Board;

(3) Comparison of the price of the drug and the price of competing drugs. For purposes of this section, the price of a drug is determined by reference to the reimbursement for the drug established under §355.8541 of this title (relating to Legend and Nonlegend Medications) and after deducting Texas and federal rebates;

(4) A program benefit offered by the manufacturer or labeler of the drug and accepted by HHSC in accordance with Texas Government Code §549.0106 [~~§531.070, Government Code~~]; and

(5) Written evidence offered by a manufacturer or labeler supporting the inclusion of a product on the PDL.

(d) Distribution of PDL. HHSC will publish the PDL on its Internet website (http://www.hhsc.state.tx.us/). A health care provider may also request a copy of the PDL from HHSC by sending a written request to the HHSC or its designee.

(e) Revisions to the PDL. Within 10 days following HHSC's decision on the recommendations of the DUR Board, HHSC will publish the revised PDL.

(f) Exclusion of a drug from the PDL. A drug that is not included in the PDL will be subject to prior authorization by HHSC or its designee in accordance with §354.1832 of this title (relating to Prior Authorization Procedures).

(g) Agreement on supplemental rebate necessary. HHSC will only include on the PDL drugs provided by a manufacturer or labeler that reaches an agreement on a supplemental rebate with HHSC in accordance with Texas Government Code §549.0106 [~~§531.070 of the Government Code~~]. Such agreement may provide for a program benefit offered by the manufacturer or labeler of the drug and accepted by HHSC in accordance with Texas Government Code §549.0106 [~~§531.070, Government Code~~].

(h) Notwithstanding subsection (g) of this section, the preferred drug list may contain a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with HHSC if HHSC determines that inclusion of the drug on the preferred drug list will have no negative cost impact to the state, in accordance with Texas Government Code §549.0204 [~~§531.072 of the Government Code~~].

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 8. DRUG UTILIZATION REVIEW BOARD

1 TAC §354.1941

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.1941. Drug Utilization Review Board.

(a) The Drug Utilization Review Board (DUR Board) must:

(1) develop recommendations for preferred drug lists to be adopted by the Texas Health and Human Services Commission (HHSC) under Texas Government Code Chapter 549, Subchapter E [~~§531.072~~];

(2) suggest to HHSC restrictions or clinical prior authorizations on prescription drugs;

(3) recommend to HHSC educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to HHSC.

(b) DUR Board membership.

(1) Membership composition complies with Social Security Act §1927(g)(3) and Texas Government Code §549.0302 [~~§531.0736~~].

(2) In accordance with Texas Government Code §549.0302 [~~§531.0736~~], the DUR Board is appointed by the HHSC Executive Commissioner. To apply to be a member of the DUR Board, a person submits, prior to the posted deadline, a completed application and required documents in accordance with the application instructions posted on HHSC's website.

(c) DUR Board meetings.

(1) HHSC publishes notice of meetings of the DUR Board. Each notice includes the categories to be considered at the upcoming meeting, instructions concerning filing of written comments, and application to provide public testimony before the DUR Board. Testimony is provided in a public forum.

(2) The DUR Board will not discuss or disclose information deemed confidential under Texas Government Code §549.0151 [~~§531.071~~] in a public session.

(d) The DUR Board or its designee must present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list that is provided to the DUR Board by a private entity that has contracted with HHSC to provide the information. The DUR Board or the DUR Board's designee must provide the summary in electronic form before the public meeting at which consideration of the drug occurs. Confidential information described by Texas Government Code §549.0151 [~~§531.071~~] must be omitted from the summary. The summary must be posted on HHSC's website.

(e) Subject to HHSC's approval, the DUR Board will develop by-laws governing the conduct of DUR Board meetings, including the receipt of public testimony and procedures by which it makes advisory recommendations. HHSC or its designee will publish these by-laws on HHSC's website.

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. QUALITY IMPROVEMENT PROCESS FOR CLINICAL INITIATIVES

1 TAC §354.2501

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.2501. Definitions.

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

(1) Advisory committee--In this subchapter, refers to an existing advisory committee that provides guidance to the HHSC executive commissioner and the agency on matters related to the Medicaid program and any quality-related issue and policy.

(2) Authorized submitter--A member of the state legislature; the executive commissioner of HHSC; commissioners of DADS, DARS, DFPS, and DSHS; and chairs of the Medical Care Advisory Committee, the Physician Payment Advisory Committee, and the Electronic Health Information Exchange System Advisory Committee may submit suggestions of clinical initiatives.

(3) Children's Health Insurance Program (CHIP)--The Texas State CHIP that is established under Title XXI of the federal Social Security Act (42 U.S.C. §§1397aa, et seq.) and Chapter 62 of the Health and Safety Code.

(4) Clinical initiative--Any effort, project, intervention, or best practice currently being explored, tested, or examined to improve the quality of care for recipients of health care services provided by public or private insurers that can potentially be implemented under the Medicaid program.

(5) Approved clinical initiative--Suggested clinical initiative that has met preliminary review criteria and been determined to warrant further analysis.

(6) Clinical trial--A clinical trial is a type of research study conducted in the clinical setting that follows a pre-determined plan or protocol that compares one treatment against another. The treatment can be a new drug, a new invasive medical device, or care protocol on human subjects.

(7) Department of Aging and Disability Services (DADS)--The HHS agency that administers long-term services and supports for people who are aging and for people with intellectual and physical disabilities. DADS also licenses and regulates providers of these services and administers the state's Guardianship program.

(8) Department of Assistive and Rehabilitation Services (DARS)--The HHS agency that administers programs for people with disabilities and children who have developmental delays.

(9) Department of Family Protective Services (DFPS)--The HHS agency that works with communities to protect children, the elderly, and people with disabilities from abuse, neglect, and exploitation. It also works to protect the health and safety of children in daycare, as well as foster care and other types of 24-hour care. The agency conducts investigations, provides services and referrals, enforces regulation, and provides prevention programs.

(10) Department of State Health Services (DSHS)--The HHS agency that is the state's designated public health agency.

(11) Electronic Health Information Exchange System Advisory Committee--The committee established under §531.904, Human Resources Code.

(12) Full analysis--A complete analysis of a suggestion for a clinical initiative that has met all preliminary review criteria. The analysis is conducted to determine whether the clinical initiative will improve quality of care under Medicaid and is cost-effective to the state. The analysis includes all elements described under Analysis of Clinical Initiative.

(13) Texas Health and Human Services Commission (HHSC)--The single state agency that administers and oversees the Texas Medicaid program. HHSC is established by and its authority is described in Texas Government Code Chapter 521 [~~Chapter 531 of the Texas Government Code~~].

(14) Institution of higher education--As defined by §61.003, Education Code, is any public technical institute, public junior college, public senior college or university, medical or dental unit, public state college, or other agency of higher education as defined in this section.

(15) Internet website--HHSC designated website related to the quality improvement process required under this subchapter.

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

(17) Medical Care Advisory Committee--The committee established under the authority of Title XIX of the Social Security Act, 42 CFR §431.12, and §32.022, Human Resource Code.

(18) Medicare--A federal system of health insurance for people over 65 years of age and for certain people younger than 65 years of age who have disabilities.

(19) Physician Payment Advisory Committee--The committee created under §32.022(d), Human Resources Code.

(20) Preliminary review--An administrative process that determines whether a suggestion for a clinical initiative warrants a full analysis.

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

(22) State-operated health care programs--In this subchapter, refers to programs that are funded solely through state general funds and operated and administered under state laws and rules.

(23) Suggestions--Proposed clinical initiatives submitted by authorized individuals either in written or electronic form.

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

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Karen Ray
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SUBCHAPTER M. MENTAL HEALTH TARGETED CASE MANAGEMENT AND MENTAL HEALTH REHABILITATION
DIVISION 1. GENERAL PROVISIONS

1 TAC §354.2603

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.2603. Definitions.

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

(1) Adult--An individual who is age 21 or older.

(2) Appeal--A mechanism for an independent review of an adverse determination or a request for a review of an action or failure to act that may result in a fair hearing.

(3) Audio-only--Has the meaning assigned by §354.1430(1) of this chapter (relating to Definitions).

(4) Behavioral health emergency--A situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalation, or verbal techniques have been determined to be ineffective and it is immediately necessary to restrain or seclude the individual to prevent:

(A) imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or

(B) imminent physical harm to others because of acts the individual commits.

(5) Case manager--A staff member of the comprehensive provider agency who provides mental health targeted case management services.

(6) CFP--Certified Family Partner. A person who meets the credentialing requirements in §353.1415(d) of this title (relating to Staff Member Credentialing).

(7) CFR--Code of Federal Regulations.

(8) Child or youth--An individual who is under age 21.

(9) Community-based--Mental health targeted case management services that are provided at a location other than the comprehensive provider agency's office.

(10) Community data--Additional information gathered during the uniform assessment.

(11) CSSP--Community services specialist. A staff member of a local mental health authority who has documented full-time experience in the provision of mental health targeted case management and mental health rehabilitative services prior to August 31, 2004. See definition in Title 26 Texas Administrative Code (TAC) §301.303 (relating to Definitions).

(12) Comprehensive provider agency--An entity that provides or subcontracts for the delivery of the full array of mental health targeted case management and mental health rehabilitative services set forth in this subchapter, with the exception of §354.2715 of this subchapter (relating to Day Programs for Acute Needs).

(13) Crisis plan--A plan developed in advance of a crisis and in collaboration with the individual, legally authorized representative (LAR), caregiver, or family of the individual receiving services that identifies circumstances that determine a crisis that would jeopardize the individual's ability to remain in the community and the actions preferred and necessary to avert removal from the community.

(14) CSU--Crisis stabilization unit. A crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and 26 TAC Chapter 510 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units).

(15) Family Psychotherapy--Therapy that focuses on the dynamics of the family unit where the goal is to strengthen the family's problem solving and communication skills.

(16) Group Psychotherapy--Therapy that involves one or more therapists working with several clients at the same time.

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

(18) IMD--Institution for mental diseases. Based on 42 CFR §435.1009, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing psychiatric diag-

nosis, treatment, or care of individuals with mental illness, including medical attention, nursing care, and related services.

(19) Independent Living--A service within psychosocial rehabilitative services that assists an individual in acquiring the most immediate, fundamental functional skills needed to enable the individual to reside in the community and avoid more restrictive levels of treatment or reducing behaviors or symptoms that prevent successful functioning in the individual's environment of choice. Such services include training in symptom management, personal hygiene, nutrition, food preparation, exercise, money management, and community integration activities.

(20) Individual--A person seeking or receiving mental health targeted case management, mental health rehabilitative services, or both under this subchapter.

(21) Individual Psychotherapy--Therapy that focuses on a single client.

(22) Intensive case management--A level of mental health targeted case management that includes a focused effort to coordinate community resources, uses evidence-based wraparound process planning to address a child's or youth's unmet needs across life domains, and assists a child or youth in gaining access to necessary care and services appropriate to the child's or youth's needs.

(23) Intensive case management plan--A written document that is part of the medical record for a child or youth receiving intensive case management and is developed by a case manager, in collaboration with the child or youth and the child's or youth's LAR or primary caregiver, that identifies services needed by the child or youth and sets forth a plan for how the child or youth may gain access to the identified services.

(24) LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this subchapter, including a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(25) Licensed medical personnel--A staff member who is:

(A) a physician;

(B) a physician assistant;

(C) an advanced practice registered nurse;

(D) a registered nurse;

(E) a licensed vocational nurse; or

(F) a pharmacist.

(26) Life domains--Areas of life, including safety, health, emotional, psychological, social, educational, cultural, and legal.

(27) LPHA--Licensed Practitioner of the Healing Arts. A staff member who is:

(A) a physician;

(B) a licensed professional counselor;

(C) a licensed clinical social worker;

(D) a licensed psychologist;

(E) an advanced practice registered nurse;

(F) a physician assistant; or

(G) a licensed marriage and family therapist.

(28) Medication training and support services--Medication training and support services consist of education and guidance about medications and their possible side effects.

(29) Mental health rehabilitative services--Services that are individualized, age-appropriate, and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance. The services are designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community.

(30) Mental health targeted case management--Services furnished to assist individuals with severe mental illness and functional impairments or serious emotional disorders and functional impairments to gain access to needed medical, social, educational, and other services.

(31) On-site--Services that are provided at a location operated by a comprehensive provider agency.

(32) Peer provider--Staff with lived experience with a mental health condition who meet the credentialing requirements in §353.1415(c) of this title.

(33) Pharmacological management--In-depth management of psychopharmacological agents to treat an individual's mental health symptoms.

(34) Platform--Has the meaning assigned by Texas Government Code §521.0001(10) [~~§531.001(4-d)~~].

(35) Primary caregiver--A person 18 years of age or older who has:

(A) actual care, control, and possession of a child or youth; or

(B) assumed responsibility for providing shelter and care for an adult.

(36) Psychiatric diagnostic evaluation--An integrated biopsychosocial assessment, including history, mental status, and recommendations.

(37) Psychosocial rehabilitative services--Social, behavioral, and cognitive interventions provided by members of an adult's therapeutic team that build on strengths and focus on restoring the adult's ability to develop and maintain social relationships, occupational or educational achievements, and other independent living skills that are affected by a serious mental illness in adults. Psychosocial rehabilitative services may also address the impact of co-occurring disorders upon the adult's ability to reduce symptomology and increase daily functioning.

(38) QMHP-CS--Qualified Mental Health Professional-Community Services. Staff who meet the credentialing requirements in §353.1415(a) of this title.

(39) Recovery--A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(40) Recovery or treatment plan (recovery/treatment plan)--A written plan that:

(A) is developed with the individual, the LAR if required, other persons whose inclusion is requested by the individual or LAR and who agree to participate, and a QMHP-CS or LPHA;

(B) is completed in conjunction with the uniform assessment;

(C) amended at any time based on an individual's needs;

(D) guides the recovery process and fosters resiliency;

(E) identifies the individual's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and

(F) identifies services and supports to meet the individual's goals, preferences, needs and desired outcomes.

(41) Recovery or treatment planning (recovery/treatment planning)--A systematic process for engaging the individual, LAR, and the primary caregiver and others to develop goals and identify a course of action to respond to the individual's clinically assessed needs, including medical, social, educational, and other services needed by the individual.

(42) Referral and linkage--Activities that help link an individual with medical, social, educational, and other providers that are capable of providing needed services.

(43) Routine care services--Mental health services provided to an individual who is not in crisis.

(44) Service provider--An entity separate from the comprehensive provider agency which may also provide services to an individual outside of the services performed under this subchapter.

(45) Staff member--Comprehensive provider agency personnel, including a full-time or part-time employee, contractor, or intern, but excluding a volunteer.

(46) Strengths-based--The concept used in service delivery that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the individual, LAR, or primary caregiver, and family, their community, and other team members. The focus is on increasing functional strengths and assets rather than on the elimination of deficits.

(47) Telehealth service--Has the meaning assigned by Texas Occupations Code §111.001(3).

(48) Telemedicine medical service--Has the meaning assigned by Texas Occupations Code §111.001(4).

(49) Therapeutic team--A group of staff members who work together in a coordinated manner for the purpose of providing comprehensive mental health services to an individual.

(50) UA--Uniform assessment. A required assessment that assists in determining the medical necessity of services. For adults, the UA includes the Adult Needs and Strengths Assessment (ANSA), community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and procedures. For children or youth, the UA includes the Child and Adolescent Needs and Strengths (CANS) assessment, community data, relevant rating scales, diagnostic information, and any other state-required assessment tools and processes.

(51) Utilization management guidelines--Guidelines developed by HHSC that establish the type, amount, and duration of mental health targeted case management services and mental health rehabilitative services for each individual.

(52) Wraparound Process Planning--A strengths-based approach used in intensive case management to develop an intensive case management plan that addresses the child's or youth's unmet needs across life domains.

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 N. PEER SPECIALIST SERVICES

DIVISION 1. GENERAL PROVISIONS

1 TAC §354.3001

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.3001. Purpose and Applicability.

(a) Peer specialists providing services under this subchapter support recipients with a mental health condition and/or substance use disorder to actively plan and work toward long-term recovery.

(b) This subchapter establishes requirements for providing peer specialist services through Medicaid and applies only to peer specialist services that are Medicaid reimbursable under this subchapter and other applicable rule or law.

(c) This subchapter implements Texas Government Code §547.0003 [~~§531.0999 of the Texas Government Code~~] and §32.024(kk) of the Texas Human Resources Code, which requires HHSC to include peer specialists as Medicaid providers.

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

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SUBCHAPTER O. ELECTRONIC VISIT VERIFICATION

1 TAC §354.4001, §354.4003

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendments affect Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.4001. Purpose and Authority.

The purpose of this subchapter is to describe requirements related to electronic visit verification authorized by:

(1) Title XIX, Section 1903(l) of the Social Security Act (42 U.S.C. §1396b(l));

(2) Texas Government Code Chapter 532, Subchapter F [~~§531.024172~~]; and

(3) Texas Human Resources Code §161.086.

§354.4003. Definitions.

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

(1) CDS employer--Consumer directed services employer. A member or the member's legally authorized representative who participates in the CDS option and whose financial management services agency (FMSA) uses an electronic visit verification (EVV) vendor system or an EVV proprietary system. A CDS employer is responsible for hiring and retaining a service provider who delivers a service described in §354.4005 of this subchapter (relating to Personal Care Services that Require the Use of EVV) or §354.4006 of this subchapter (relating to Home Health Care Services that Require the Use of EVV).

(2) CDS option--Consumer directed services option. A service delivery option in which a CDS employer employs and retains a service provider and directs the delivery of a service described in §354.4005 or §354.4006 of this subchapter.

(3) CFC--Community First Choice. A Medicaid state plan option governed by Code of Federal Regulations, Title 42, Part 441, Subpart K, Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice). CFC services include the following.

(A) CFC HAB--CFC habilitation. A Medicaid state plan service that provides habilitation through CFC as described in §354.1361 of this chapter (relating to Definitions).

(B) CFC PAS--CFC personal assistance services. A Medicaid state plan service that provides personal assistance services through CFC as described in §354.1361 of this chapter.

(C) CFC PAS/HAB--CFC personal assistance services/habilitation. A Medicaid state plan service provided through CFC that provides both personal assistance services and habilitation.

(4) CLASS Program--Community Living Assistance and Support Services Program. A Medicaid waiver program approved by the Centers for Medicare & Medicaid Services under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 259 (relating to Community Living Assistance and Support Services (CLASS) Program and Community First Choice (CFC) Services).

(5) CMS--Centers for Medicare & Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

(6) Community Attendant Services Program--A Medicaid state plan program operating under Title XIX of the Social Security Act, as described in 40 TAC Chapter 47 (relating to Primary Home Care, Community Attendant Services, and Family Care Programs).

(7) DBMD Program--Deaf Blind with Multiple Disabilities. The Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 260 (relating to Deaf Blind with Multiple Disabilities (DBMD) Program and Community First Choice (CFC) Services).

(8) EVV--Electronic visit verification. The documentation and verification of service delivery through an EVV system.

(9) EVV aggregator--A centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system.

(10) EVV claim--A request for payment of a service described in §354.4005 or §354.4006 of this subchapter submitted to HHSC, HHSC's designated contractor, or a managed care organization (MCO) in accordance with the EVV Policy Handbook.

(11) EVV Policy Handbook--A handbook promulgated by HHSC that contains policies and requirements related to EVV.

(12) EVV portal--An online system established by HHSC that allows users to perform searches, view reports and view EVV claim match results associated with data in the EVV aggregator.

(13) EVV portal user--A person who is employed by or contracts with a program provider or FMSA and has access to the EVV portal.

(14) EVV proprietary system--An HHSC EVV system purchased or developed by a program provider or FMSA approved by HHSC in accordance with §354.4013 of this subchapter (relating to HHSC and MCO Compliance Reviews and Enforcement Actions) that a program provider or FMSA uses instead of an EVV vendor system.

(15) EVV system--An EVV vendor system or an EVV proprietary system used to electronically document and verify the data elements described in §354.4009(a) of this subchapter (relating to EVV Visit Transaction and EVV Claim) for a visit conducted to provide a service described in §354.4005 or §354.4006 of this subchapter.

(16) EVV system user--A person who has access to the EVV system, including a person employed by or contracting with a program provider, FMSA, or CDS employer.

(17) EVV vendor system--An EVV system developed and operated by a vendor that contracts with HHSC or HHSC's designated contractor that a program provider or FMSA uses instead of an EVV proprietary system.

(18) EVV visit transaction--A record generated by an EVV system that contains the data elements described in §354.4009(a) of this subchapter for a visit conducted to provide a service described in §354.4005 or §354.4006 of this subchapter.

(19) FC Program--Family Care Program. A program funded under Title XX, Subtitle A of the Social Security Act, as described in 40 TAC Chapter 47.

(20) FMSA--Financial management services agency. A program provider that contracts with HHSC or an MCO to provide financial management services to a CDS employer as described in 40 TAC Chapter 41 (relating to Consumer Directed Services Option).

(21) HCBS-AMH Program--Home and Community-Based Services Adult Mental Health Program. A Medicaid state plan option approved by CMS under Title XIX, Section 1915(i) of the Social Security Act, as described in 26 TAC Chapter 307, Subchapter B (relating

to Home and Community-Based Services--Adult Mental Health Program).

(22) HCS Program--Home and Community-based Services Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 263 (relating to Home and Community-based Services (HCS) Program and Community First Choice (CFC)).

(23) HHSC--Texas Health and Human Services Commission.

(24) Home health aide--Has the meaning set forth in 26 TAC §558.2 (relating to Definitions).

(25) ICF/IID--Intermediate care facility for individuals with an intellectual disability or related conditions. An ICF/IID is a facility that is licensed in accordance with THSC Chapter 252 or certified by HHSC.

(26) IMD--Institution for mental diseases. Has the meaning set forth in 25 TAC §419.373 (relating to Definitions).

(27) LVN--Licensed vocational nurse. A person licensed to practice as a vocational nurse as described in Texas Occupations Code Chapter 301.

(28) MCO--Managed care organization. Has the meaning set forth in Texas Government Code §543A.0001 [~~§536.001~~].

(29) MDCP--Medically Dependent Children Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in Chapter 353, Subchapter M of this title (relating to Home and Community Based Services in Managed Care).

(30) MDCP STAR Health covered service--Medically Dependent Children Program STAR Health covered service. A service provided to a member eligible to receive MDCP benefits under the STAR Health Program.

(31) MDCP STAR Kids covered service--Medically Dependent Children Program STAR Kids covered service. A service provided to a member eligible to receive MDCP benefits under the STAR Kids Program.

(32) Member--A person enrolled in one of the following:

(A) traditional Medicaid service delivery model also referred to as fee-for-service;

(B) the CLASS Program;

(C) the Community Attendant Services Program;

(D) the DBMD Program;

(E) the FC Program;

(F) the HCBS-AMH Program;

(G) the HCS Program;

(H) the Primary Home Care Program;

(I) the STAR Program;

(J) the STAR Health Program;

(K) the STAR Kids Program;

(L) the STAR+PLUS Program;

(M) the STAR+PLUS Home and Community-Based Services Program;

(N) the STAR+PLUS Medicare-Medicaid Program;

(O) the Texas Home Living Program;

(P) Texas Health Steps Comprehensive Care Program (CCP); or

(Q) the Youth Empowerment Services Program.

(33) Nursing facility--A facility licensed in accordance with Texas Health and Safety Code Chapter 242.

(34) Occupational therapist--A person licensed as an occupational therapist in accordance with Texas Occupations Code Chapter 454.

(35) PCS--Personal Care Services. Support services provided to a member enrolled in Texas Health Steps CCP who requires assistance with activities of daily living or instrumental activities of daily living as described in §363.602 of this title (relating to Definitions).

(36) PDN--Private duty nursing. Has the same meaning as the term "Private duty nursing (PDN) Services" in 1 TAC Chapter 363, Subchapter C, §363.303 (relating to Definitions).

(37) Primary Home Care Program--A Medicaid state plan program operating under Title XIX of the Social Security Act, as described in 40 TAC Chapter 47.

(38) Physical therapist--A person licensed as a physical therapist in accordance with Texas Occupations Code Chapter 453.

(39) Program provider--An entity that contracts with HHSC or an MCO to provide a service described in §354.4005 or §354.4006 of this subchapter and that uses an EVV vendor system or an EVV proprietary system. A service provider described in paragraph (43)(B) of this section is both a program provider and a service provider.

(40) PSO--Proprietary system operator. A program provider or FMSA that uses an EVV proprietary system.

(41) Reason code--A standardized HHSC-approved code entered in an EVV system to explain the reason for completing visit maintenance.

(42) RN--Registered nurse. A person licensed to practice as a registered nurse as described in Texas Occupations Code Chapter 301.

(43) Service provider--A person who provides a service described in §354.4005 or §354.4006 of this subchapter and who:

(A) is employed by or contracting with:

(i) a program provider; or

(ii) a CDS employer; or

(B) who is contracting with:

(i) an MCO; or

(ii) HHSC.

(44) SRO--Service responsibility option. A service delivery option described in 40 TAC Chapter 43 (relating to Service Responsibility Option) in which a member or legally authorized representative selects, trains, and provides daily management of a service provider, while the fiscal, personnel, and service back-up plan responsibilities remain with the program provider.

(45) STAR--State of Texas Access Reform.

(46) STAR Health Program--A Medicaid program operating under Title XIX, Section 1915(a) of the Social Security Act and

Texas Family Code, Chapter 266. The program provides services through a managed care delivery model to a member enrolled in STAR Health as described in Chapter 353, Subchapter H of this title (relating to STAR Health).

(47) STAR Kids Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act and Texas Government Code Chapter 540 [~~533~~]. The program provides services through a managed care delivery model to a member enrolled in STAR Kids as described in Chapter 353, Subchapter N of this title (relating to STAR Kids).

(48) STAR Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act. The program provides services through a managed care delivery model to a member enrolled in STAR as described in Chapter 353, Subchapter I of this title (relating to STAR).

(49) STAR+PLUS HCBS Program--STAR+PLUS Home and Community-Based Services Program. A Medicaid program operating through a federal waiver under Title XIX, Section 1115 of the Social Security Act. The program provides services to a member eligible to receive HCBS benefits under the STAR+PLUS Program, as described in Chapter 353, Subchapter M of this title (relating to Home and Community Based Services in Managed Care).

(50) STAR+PLUS MMP--STAR+PLUS Medicare-Medicaid Plan. A managed care program operating under Title XIX, Section 1115A of the Social Security Act that provides the authority to test and evaluate a fully integrated care model for clients who are dual eligible. The STAR+PLUS MMPs contract with CMS and HHSC to participate in the Dual Demonstration Program described in Chapter 353, Subchapter L of this title (relating to Texas Dual Eligibles Integrated Care Demonstration Project).

(51) STAR+PLUS Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act, and Texas Government Code Chapter 540 [~~533~~]. The program provides services through a managed care delivery model to a member enrolled in STAR+PLUS as described in Chapter 353, Subchapter G of this title (relating to STAR+PLUS).

(52) TAC--Texas Administrative Code.

(53) Texas Health Steps CCP--Texas Health Steps Comprehensive Care Program. A Medicaid comprehensive program approved by CMS under Title XIX, Section 1905 of the Social Security Act, as described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program.

(54) TxHmL--Texas Home Living Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 262 (relating to Texas Home Living (TxHmL) Program and Community First Choice (CFC)).

(55) Vendor hold--A temporary suspension of payments for claims that are due to a program provider or FMSA.

(56) Visit maintenance--As described in the EVV Policy Handbook, a process to:

(A) manually enter data elements described in §354.4009(a) of this subchapter in an EVV system;

(B) correct the data elements described in §354.4009(a) of this subchapter that are inaccurate in an EVV visit transaction; or

(C) include the data elements described in §354.4009(a) of this subchapter that are missing in an EVV visit transaction.

(57) YES Program--Youth Empowerment Services Program. A Medicaid waiver approved by CMS under Title XIX, Section 1915(c) of the Social Security Act as described in 26 TAC Chapter 307, Subchapter A (relating to Youth Empowerment Services (YES)).

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 P. AUTISM SERVICES
DIVISION 2. SERVICE PROVIDERS

1 TAC §354.5011

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 Chapters 521, 524, 532, 543A, 547, 548, and 549.

The amendment affects Texas Government Code §531.0055 and Chapters 521, 524, 532, 543A, 547, 548, and 549.

§354.5011. Providers of Applied Behavior Analysis (ABA) Services.

(a) Providers of ABA services include:

(1) LBAs who:

(A) practice within the LBA's state scope of practice and licensure requirements, meet all relevant provider qualifications, and comply with all applicable law, rules, and requirements under this subchapter;

(B) are currently enrolled in Texas Medicaid through TMHP;

(C) for claims submission purposes, serve as the Medicaid enrolled rendering provider for all ABA evaluation, treatment, and supervision services, including those ABA services rendered under the LBA's supervision by an LaBA or a BT, as applicable, where the rendering provider for the specific service, which may be the LBA, LaBA, or BT, may or must, as applicable, be indicated on the claim with an appropriate Medicaid modifier; and

(D) may provide the following Medicaid reimbursable ABA services when authorized:

(i) ABA evaluation and treatment services to the child;

(ii) education and training services to the LAR, parent, or caregiver, as applicable;

(iii) supervision services for the LaBA or BT, as applicable, to whom the LBA has delegated service delivery; and

(iv) required participation in ABA-related interdisciplinary team meetings, if utilized.

(2) LaBAs who:

(A) practice within the LaBA's state scope of practice and licensure requirements, meet all relevant provider qualifications and comply with all applicable law, rules, and requirements under this subchapter; and

(B) are not Medicaid enrolled but rather render in-person ABA treatment services, parent or caregiver education and training services, or supervision services for a BT, under the supervision of the enrolled LBA.

(3) BTs who:

(A) are currently fully registered or certified as a BT under this subchapter and meet all other relevant provider qualifications;

(B) practice in accordance with their national certification or registration requirements and as directed by the supervising LBA or LaBA, to ensure compliance with all applicable law, rules, and requirements under this subchapter; and

(C) are not Medicaid enrolled but rather render in-person ABA treatment services under the supervision of the enrolled LBA or the LaBA.

(4) Licensed professionals who:

(A) are described in the Autism Section in the TMPPM as eligible licensed professionals for participation in ABA-related interdisciplinary team meetings, other than LBAs; and

(B) participate in Medicaid reimbursable ABA-related interdisciplinary team meetings to coordinate care for the child when eligible.

(b) Providers of ABA services must comply with:

(1) all applicable state and federal law or rule, such as:

(A) Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) (relating to Grants to States for Medical Assistance Programs);

(B) 42 CFR §440.40(b) (relating to EPSDT) and §§441.50 - 441.62 (relating to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21);

(C) Texas Human Resources Code Chapter 32 (relating to Medical Assistance Program);

(D) Texas Government Code Chapter 521 [~~531~~] (relating to Health and Human Services Commission);

(E) Chapter 352 of this title (relating to Medicaid and Children's Health Insurance Program Provider Enrollment);

(F) Chapter 353 of this title (relating to Medicaid Managed Care);

(G) Chapter 354 of this title (relating to Medicaid Health Services);

(H) Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program); and

(I) 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment);

(2) the Texas Medicaid Provider Agreement, as applicable;

(3) the NCCI;

(4) the current TMPPM, including:

(A) all published updates, including updates made available through bulletins, banners, or other means, and any revisions of published updates;

(B) all published handbooks, standards, and guidelines; and

(C) the specific ABA service requirements in this subchapter and the Autism Section in the TMPPM;

(5) Texas Family Code Chapter 261 (relating to Investigation of Report of Child Abuse or Neglect); and

(6) retrospective reviews, which include reviews of providers and provider locations, activities, and records to confirm compliance with all applicable law or rule, and other applicable requirements under 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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CHAPTER 355. REIMBURSEMENT RATES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §355.201, concerning Establishment and Adjustment of Reimbursement Rates for Medicaid; §355.311, concerning Medicaid Reimbursement Rates for State Veterans Homes; §355.7001, concerning Reimbursement Methodology for Telemedicine, Telehealth, and Home Telemonitoring Services; §355.8200, concerning Retained Funds for the Uncompensated Care Program; and §355.8261, concerning Federally Qualified Health Center Services Reimbursement.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

Trey Wood, HHSC Chief Financial Services 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 not create a new regulation;

(6) the proposed rules will not expand, limit, or 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.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules because the amendments only update references to existing laws.

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

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social 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 amendments only update references to existing laws.

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 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 24R084" in the subject line.

SUBCHAPTER B. ESTABLISHMENT AND ADJUSTMENT OF REIMBURSEMENT RATES FOR MEDICAID

1 TAC §355.201

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 Chapters 532, 540, and 548.

The amendment affects Texas Government Code §531.0055 and Chapters 532, 540, and 548.

§355.201. Establishment and Adjustment of Reimbursement Rates for Medicaid.

(a) Definitions. Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:

(1) 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.

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

(3) Medical assistance--A medical or health care related service, item, or supply that is delivered to a Medicaid recipient and is approved and authorized for payment or reimbursement by HHSC or CMS pursuant to state and federal law.

(4) Program--A specific component of the Medicaid program for which HHSC establishes either a methodology to reimburse a provider or a specific fee, payment rate, or charge that is paid to a provider for medical assistance in accordance with state and federal law.

(5) Provider--A health care practitioner, institution, or other entity that is enrolled in the medical assistance program and is authorized to submit claims for payment or reimbursement of medical assistance.

(b) Purpose. This section implements Texas Government Code §532.0057 [~~§531.021(d) and (e)~~], and applies to all programs that provide medical assistance and to all reimbursement methodologies related to medical assistance prescribed under this chapter.

(c) Establishment of fees, rates, and charges. HHSC establishes fees, rates, and charges to be paid for medical assistance in accordance with:

(1) the formulas, procedures, or methodologies prescribed in this chapter;

(2) applicable state or federal law, policies, rules, regulations, or guidelines;

(3) economic conditions that, in HHSC's determination, substantially and materially affect provider participation; or

(4) available levels of appropriated state and federal funds.

(d) Adjustment of fees, rates, and charges. Notwithstanding any other provision of this chapter, HHSC may adjust fees, rates, and charges paid for medical assistance as necessary to achieve the objectives of Medicaid in a manner consistent with the considerations described in subsection (c) of this section.

(e) Notice. If HHSC establishes or adjusts fees, rates, or charges under this section, HHSC will hold a public hearing and provide notice of the hearing in accordance with §355.105(g) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

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

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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.311

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 Chapters 532, 540, and 548.

The amendment affects Texas Government Code §531.0055 and Chapters 532, 540, and 548.

§355.311. Medicaid Reimbursement Rates for State Veterans Homes.

(a) The following definitions apply to this section:

(1) Health and Human Services Commission (HHSC)--The state administrative agency authorized to adopt standards and rules to govern reimbursement rates and methodologies for Medicaid nursing facility services pursuant to Government Code §532.0051 [~~§531.021~~].

(2) Rate period--The state fiscal year.

(3) State veterans home--A nursing facility as defined in Title 40, Texas Administrative Code (TAC) §176.1 (relating to Definitions) that is contracted with the Department of Aging and Disability Services (DADS) under 40 TAC §19.2322 (relating to Medicaid Bed Allocation Requirements) to provide nursing facility services to eligible Medicaid recipients who reside in a state veterans home.

(4) Department of Aging and Disability Service (DADS)--The state administrative agency authorized to contract for nursing facility services to Medicaid recipients pursuant to Chapter 32, Human Resources Code.

(5) Veterans Land Board (VLB)--The state administrative agency authorized under Chapter 164, Natural Resources Code, to establish and operate state veterans homes.

(b) DADS reimburses the VLB for nursing facility services provided by the VLB to Medicaid clients in state veterans homes.

(c) HHSC determines reimbursement rates for state veterans homes to provide nursing facility services.

(d) Interim reimbursement rates for state veterans homes are determined prospectively for each home based on the state veterans home semi-private basic daily rate in effect on the first day of the rate period. Rates are reconciled retrospectively based on actual cost in accordance with subsection (j) of this section.

(e) The facility-specific payment rate, as determined in subsection (d) of this section, will be paid for all Medicaid eligible residents of a state veterans home regardless of the case mix classification of the resident.

(f) Veterans Administration (VA) per diem payments to the State of Texas VLB for nursing home care as defined in 38 Code of Federal Regulations (CFR) §51.40 (relating to monthly payment) are not offset against per diem payment rates for Medicaid-eligible residents of a state veterans home.

(g) Residents of a state veterans home are not eligible to receive the supplemental reimbursements authorized under §355.307(b)(3)(E) and (F) of this title (relating to Reimbursement Setting Methodology).

(h) State veterans homes are not eligible to participate in §355.308 of this title (relating to Direct Care Staff Rate Component).

(i) The VLB submits financial and statistical information in a format designated by HHSC. The financial and statistical information must be completed in accordance with the provisions of §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs; and Specifications for Allowable and Unallowable Costs). This information may be reviewed or audited in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). Financial and statistical information submitted by the VLB is not included in the cost report databases used in the reimbursement determination process for the Texas Medicaid Nursing Facility program.

(j) For each state veterans home, the interim reimbursement rate is adjusted retrospectively based on actual costs accrued during the rate period.

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

1 TAC §355.7001

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 Chapters 532, 540, and 548.

The amendment affects Texas Government Code §531.0055 and Chapters 532, 540, and 548.

§355.7001. Reimbursement Methodology for Telemedicine, Telehealth, and Home Telemonitoring Services.

(a) Eligible providers performing telemedicine medical, telehealth, or home telemonitoring services are defined in §354.1430 of this title (relating to Definitions), §354.1432 of this title (relating to Telemedicine and Telehealth Benefits and Limitations), and §354.1434 of this title (relating to Home Telemonitoring Benefits and Limitations).

(b) The Health and Human Services Commission (HHSC) reimburses eligible distant site professionals providing telemedicine medical services as follows:

(1) Physicians are reimbursed for their Medicaid telemedicine medical services in the same manner as their other professional services in accordance with §355.8085 of this title (relating to Reimbursement Methodology for Physicians and Other Practitioners).

(2) Physician assistants are reimbursed for their Medicaid telemedicine medical services in the same manner as their other professional services in accordance with §355.8093 of this title (relating to Reimbursement Methodology for Physician Assistants).

(3) Advanced Practice Registered Nurses (APRNs) are reimbursed for their Medicaid telemedicine medical services in the same manner as their other professional services in accordance with §355.8281 of this title (relating to Reimbursement Methodology for Nurse Practitioners and Clinical Nurse Specialists).

(4) Certified nurse midwives are reimbursed for their Medicaid telemedicine medical services in the same manner as their other professional services in accordance with §355.8161 of this title (relating to Reimbursement Methodology for Midwife Services).

(c) HHSC reimburses eligible distant site professionals providing telehealth services as follows:

(1) Licensed professional counselors, including licensed marriage and family therapists, and licensed clinical social workers (including Comprehensive Care Program social workers) are reimbursed for their Medicaid telehealth services in the same manner as their other professional services in accordance with §355.8091 of this title (relating to Reimbursement to Licensed Professional Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists).

(2) Licensed psychologists (including licensed psychological associates) and psychology groups are reimbursed for their Medicaid telehealth services in the same manner as their other professional services in accordance with §355.8085 of this title.

(3) Durable medical equipment suppliers are reimbursed for their Medicaid telehealth services in the same manner as their other professional services in accordance with §355.8023 of this title (relating to Reimbursement Methodology for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)).

(d) Telemedicine and telehealth patient site locations, as defined in §354.1430 and §354.1432 of this title, are reimbursed a facility fee determined by HHSC.

(e) HHSC reimburses eligible providers performing home telemonitoring services in the same manner as their other professional services described in §355.8021 of this title (relating to Reimbursement Methodology for Home Health Services).

(f) Telemedicine medical services provided in a school-based setting by a physician, even if the physician is not the patient's primary care physician, will be reimbursed in accordance with the applicable methodologies described in subsection (b)(1) of this section and §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)) if the following conditions are met:

(1) the physician is an authorized health care provider under Medicaid;

(2) the patient is a child who receives the service in a primary or secondary school-based setting;

(3) the parent or legal guardian of the patient provides consent before the service is provided; and

(4) a health professional as defined by Texas Government Code §548.0101 [~~Government Code §531.0217(a)(1)~~] is present with the patient during the treatment.

(g) Fees for telemedicine, telehealth, and home telemonitoring services are adjusted within available funding as described in §355.201 of this title (relating to Establishment and Adjustment of Reimbursement Rates by the 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.

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SUBCHAPTER J. PURCHASED HEALTH SERVICES
DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8200

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 Chapters 532, 540, and 548.

The amendment affects Texas Government Code §531.0055 and Chapters 532, 540, and 548.

§355.8200. Retained Funds for the Uncompensated Care Program.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program under §1115(a), Medicaid demonstration waiver payments available under this division help to defray the uncompensated cost of charity care provided by eligible hospitals and physician practices on or after October 1, 2019. Participation in the Texas Healthcare Transformation and Quality Improvement Program is subject to an application fee.

(b) Definition. A non-public provider, when the term is used in this section, is defined as a provider who is owned by any entity other than a unit of local, state, or federal government.

(c) Applicability. The requirement to submit an application fee applies to all non-public providers in the state.

(d) Application Fee. An application fee will be required with the submission of the application described in §355.8212(c)(2) of this subchapter.

(1) The application fee will be determined annually based upon an estimate of the amount equal to the estimated costs necessary to administer the program and will be posted on the Texas Health and Human Services Commission Provider Finance Department website.

(2) Payment is due at the time of the submission of the application. If no payment is received with the application, an account receivable will be established. HHSC will offset the next applicable payment to the provider against the account receivable until the obligation to the state is discharged.

(3) Payment must be made in the manner determined by HHSC and in compliance with payment instructions that will be posted on the HHSC Provider Finance Department website.

(e) Uses of the Funds and Limitations.

(1) The total amount received from the application fee may not exceed $8,000,000 annually when combined with any other funds retained under the authority of Texas Government Code §532.0102 [~~§531.021135~~].

(2) HHSC will spend money retained under this section to assist in paying the costs necessary to administer the program for which the money is received. HHSC will not use the money to pay any type of administrative cost that was funded with general revenue before June 1, 2019.

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 14. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

1 TAC §355.8261

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 Chapters 532, 540, and 548.

The amendment affects Texas Government Code §531.0055 and Chapters 532, 540, and 548.

§355.8261. Federally Qualified Health Center Services Reimbursement.

(a) Prospective Payment System (PPS) Methodology. Federally Qualified Health Centers (FQHCs) selecting the PPS methodology, in accordance with section 1902(bb) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000 (42 U.S.C. §1396a(bb)), effective for the FQHC's fiscal year that includes dates of service occurring January 1, 2001, and after, will be reimbursed a PPS per visit encounter rate for Medicaid covered services. FQHCs are reimbursed a prospective per visit encounter rate for a visit that meets the requirements of subsections (b)(12) and (13) of this section. The final base rate for each FQHC existing in 2000 was calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The final base rate was calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. The reimbursement methodologies described in subsection (b) of this section apply to the PPS methodology, except for the following:

(1) The effective rate for APPS described in subsection (b)(4) of this section does not apply to PPS. Increases in the final base rate or the effective rate for a PPS-reimbursed FQHC shall be the rate of change in the Medicare Economic Index (MEI) for primary care. If the increase in an FQHC's costs is greater than the MEI for PPS, an FQHC may request an adjustment of its effective rate as described in subsection (b)(6) of this section.

(2) State initiated reviews, described in subsection (b)(10)(D) of this section, are not applicable for providers who select the PPS methodology.

(b) Alternative Prospective Payment System (APPS) Methodology. FQHCs selecting the APPS methodology, in accordance with section 1902(bb) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000 (42 U.S.C. §1396a(bb)), effective for the FQHC's fiscal year that includes dates of service occurring January 1, 2001, and after, are reimbursed an APPS per visit encounter rate for Medicaid covered services at one hundred percent (100%) of reasonable costs. FQHCs are reimbursed a prospective per visit encounter rate for a visit that meets the requirements of paragraphs (12) and (13) of this subsection. The final base rate for each FQHC existing in 2000 was calculated based on one hundred percent (100%) of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The final base rate was calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods.

(1) Prior to the Health and Human Services Commission (HHSC) setting a final base rate pursuant to this section for each FQHC existing in 2000, each FQHC was reimbursed on the basis of an interim base rate. The interim base rate for each FQHC was calculated from the latest finalized cost report settlement, adjusted as provided for in paragraph (4) of this subsection. When HHSC determined a final base rate, interim payments were reconciled back to the beginning of the interim period. For FQHCs that agreed to the APPS methodology prior to August 31, 2010, adjustments were made to the FQHC's interim payments only if the interim payments were less than what would have occurred under the final base rate. Paragraph (10) of this subsection contains the interim and final base rate methodology for new FQHCs. The final base rate, as adjusted, applies prospectively from the date of the final approval. Payments made under the APPS methodology will be at least equal to the amount that would be paid under PPS.

(2) Reasonable costs, as used in setting the interim or final base rate or any subsequent effective rate, is defined as those costs that are allowable under Medicare Cost Principles, as outlined in 42 C.F.R. part 413, with no productivity screens and no per visit payment limit. Administrative costs will be limited to thirty percent (30%) of total costs in determining reasonable costs. Reasonable costs do not include unallowable costs.

(3) Unallowable costs are expenses that are incurred by an FQHC and that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules, and standards. An FQHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating an interim or final base rate determination. Unallowable costs include, but are not necessarily limited to, the following:

(A) compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(B) personal expenses not directly related to the provision of covered services;

(C) management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(D) advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(E) business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(F) political contributions;

(G) depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(H) trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(I) donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 C.F.R. part 413;

(J) dues to all types of political and social organizations and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs or the rendering of patient care services;

(K) entertainment expenses, except those incurred for entertainment provided to the staff of the FQHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(L) board of director's fees, including travel costs and meals provided for directors;

(M) fines and penalties for violations of statutes, regulations, and ordinances of all types;

(N) fund raising and promotional expenses, except as noted in subparagraph (D) of this paragraph;

(O) interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid that is reduced or offset by interest income;

(P) insurance premiums pertaining to items of unallowable costs;

(Q) any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(R) mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(S) cost for goods or services that are purchased from a related party and that exceed the original cost to the related party;

(T) out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses that increase the quality of medical care and/or the operating efficiency of the FQHC;

(U) over-funding contributions to self-insurance funds that do not represent payments based on current liabilities;

(V) overhead costs beyond the thirty percent (30%) limitation established by HHSC.

(4) The effective rate for APPS - The effective rate is the rate paid to the FQHC for the FQHC's fiscal year. The effective rate shall be updated by the rate of change in the MEI plus (0.5) percent for each of the FQHC's fiscal years since the setting of its final base rate. If the increase in an FQHC's costs is greater than the MEI plus (0.5) percent for APPS, an FQHC may request an adjustment of its effective rate as described in paragraph (6) of this subsection. The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year. The effective rate for PPS is described in subsection (a)(1) of this section.

(5) PPS and APPS reimbursement methodology selection is determined as follows:

(A) Each new in-state FQHC will receive a letter from HHSC upon enrollment as a new provider along with the Federally Qualified Health Centers (FQHC) Prospective Payment System Form. This form must be signed by an authorized representative and returned to HHSC within thirty (30) days of the enrollment letter date. The form

must indicate the selection as either the PPS or APPS reimbursement methodology. If HHSC does not receive the form within the specified time requirement, HHSC will select the PPS reimbursement methodology for this provider. For a provider that fails to return the form selecting the APPS reimbursement methodology, the provider may submit a written request along with the Federally Qualified Health Centers (FQHC) Prospective Payment System Form selecting the APPS reimbursement methodology. Upon approval by HHSC, the new selection will be effective the first day of the provider's next fiscal year.

(B) Each out-of-state FQHCs will receive the PPS reimbursement methodology. Out-of-state FQHCs may not select the APPS reimbursement methodology. HHSC will compute an effective rate based on reasonable costs provided by the FQHC on its most recent Medicare cost report, pursuant to paragraph (8)(A) and (B) of this subsection. The effective rate will reflect the rate that would have been calculated for an in-state FQHC based on the approved scope of services that an in-state FQHC could provide in Texas.

(C) When HHSC makes a change to the PPS or APPS reimbursement methodology, HHSC may require FQHCs to reselect the PPS or APPS reimbursement methodology, in accordance with the requirements of subparagraph (A) of this paragraph.

(6) A change of the effective rate is determined as follows:

(A) An adjustment, as described in paragraph (10)(C) of this subsection, will be made to the effective rate if the FQHC can show that it is operating in an efficient manner as defined in paragraph (7)(B) of this subsection, or show that the adjustment is warranted due to a change in scope as defined in paragraph (7)(A) of this subsection.

(B) HHSC also may adjust the effective rate of an FQHC on its own initiative, in accordance with paragraph (10)(D) of this subsection, if it is determined that a change of scope has occurred and an adjustment to the effective rate as defined in paragraph (7) of this subsection is warranted based on the audit of the cost report described in paragraph (8)(C) of this subsection.

(7) Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope. A change in scope provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC's sites.

(A) A change in scope includes:

(i) an increase in service intensity attributable to changes in the types of patients served, including but not limited to, patients with HIV/AIDS, the homeless, the elderly, migrants, those with other chronic diseases or special populations;

(ii) any changes in services or provider mix provided by an FQHC or one of its sites;

(iii) changes in operating costs that have occurred during the fiscal year and which are attributable to capital expenditures, including new service facilities or regulatory compliance;

(iv) changes in operating costs attributable to changes in technology or medical practices at the FQHC;

(v) indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(vi) any changes in scope approved by the Health Resources and Service Administration (HRSA).

(B) Operating in an efficient manner includes:

(i) showing that the FQHC has implemented an outcome-based delivery system that includes prevention and chronic disease management. Prevention includes, but is not limited to, programs such as immunizations and medical screens. Disease Management must include, but not be limited to, programs such as those for diabetes, cardiovascular conditions, and asthma that can demonstrate an overall improvement in patient outcome;

(ii) paying employees' salaries that do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

(iii) providing fringe benefits to its employees that do not exceed fifteen percent (15%) of the FQHC's total costs;

(iv) implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

(v) employing the Medicare concept of a "prudent buyer" in purchasing its contracted medical services.

(8) Cost report forms and worksheets are required as follows:

(A) As-Filed Medicare Cost Report. The As-Filed Medicare Cost Report includes:

(i) CMS form 222-92 Independent Rural Health Clinic/Freestanding and Federally Qualified Health Center Worksheet, including the HCFA 339 Form.

(I) Worksheet S part 1 - Statistical Data;

(II) Worksheet S part 2 - Certification By Officer or Administrator;

(III) Worksheet S part 3 - Statistical Data for Clinics Filing Under Consolidated Cost Reporting;

(IV) Worksheet A page 1 - Reclassification and Adjustment of Trial Balance of Expenses;

(V) Worksheet A page 2 - Reclassification and Adjustment of Trial Balance of Expenses;

(VI) Worksheet A-1 - Reclassifications;

(VII) Worksheet A-2 - Adjustments to Expenses;

(VIII) Worksheet A-2-1, Parts I to III - Statement of Cost of Services from Related Organizations;

(IX) Worksheet B part I and II - Visits and Overhead Cost for RHC/FQHC Services; and

(X) Worksheet C part I and II - Determination of Medicare Reimbursement.

(ii) Texas Medicaid Supplemental Worksheets.

(I) Determination of FQHC Cost Based Rate;

(II) Exhibit 1 - Determination of FQHC Medicaid Reimbursable Cost - Rate Worksheet;

(III) Exhibit 2 - Visit Reconciliation - Employed Providers; and

(IV) Exhibit 3 - Visit Reconciliation - Contract Service Providers.

(iii) Trial Balance with account titles. If the provider's Trial Balance has only account numbers, a Chart of Accounts will need to accompany the Trial Balance.

(iv) A mapping of the Trial Balance that shows the tracing of each Trial Balance account to a line and column on Worksheet A pages 1 and 2.

(v) Documentation supporting the provider's reclassification and adjustment entries.

(vi) A Schedule of Depreciation of depreciable assets.

(vii) A listing of all satellites, if applicable.

(viii) Federal Grant Award notices or changes in scope approved by HRSA.

(ix) All items must be complete and accurate.

(B) Final Audited Medicare Cost Report. In-state providers must file the final audited cost report received from Medicare, as required in paragraph (9) of this subsection. The final audited Medicare cost report includes:

(i) A copy of the final audited CMS form 222-92 Independent Rural Health Clinic/Freestanding and Federally Qualified Health Center Worksheets, including the HCFA 339 Form filed with Medicare.

(ii) Texas Medicaid Supplemental Worksheets.

(I) Determination of FQHC Cost Based Rate;

(II) Exhibit 1 - Determination of FQHC Medicaid Reimbursable Cost - Rate Worksheet;

(III) Exhibit 2 - Visit Reconciliation - Employed Providers; and

(IV) Exhibit 3 - Visit Reconciliation - Contract Service Providers.

(iii) All items must be complete and accurate.

(C) Change of Effective Rate Cost Report. The change of effective rate cost report is used by in-state or out-of-state FQHCs that are requesting a change in their effective rate due to a change in scope or operating in an efficient manner. The cost report must contain at least six (6) months of financial information. The documents needed for in-state and out-of-state providers filing a change of effective rate cost report are the same as required for the as-filed cost report in paragraph (8)(A) of this subsection.

(D) Projected Cost Report. The projected cost report is used by in-state or out-of-state FQHCs that are requesting an initial interim rate. The cost report must contain at least twelve (12) months of projected financial information. The required documents are the same as required for the as-filed cost report in paragraph (8)(A) of this subsection, except that the information contained in clauses (iii), (iv) and (v) are not required.

(E) Low Medicare Utilization Cost Report. The low Medicare utilization cost report is used by in-state and out-of-state providers to meet the annual filing requirements for providers not required to file a full cost report with Medicare. A provider filing the Low Medicare Utilization cost report must complete and submit all required forms and supporting documentation described in paragraph (8)(A) of this subsection for all rate determination processes described in paragraph (10) of this subsection.

(F) If a provider fails to submit a required cost report, HHSC or its designee may delay or withhold vendor payment to the provider until a complete cost report has been received and accepted by HHSC or its designee.

(9) Cost Report Filing Requirement. Each FQHC must submit a copy of its Final Audited Medicare Cost Report, as described in paragraph (8)(B) of this subsection, to HHSC or its designee within thirty (30) days of receipt of the report from Medicare. An FQHC filing a Low Utilization Cost Report with Medicare may comply with this subsection by filing a copy of such cost report with HHSC annually, within thirty (30) days of filing the report with Medicare.

(10) FQHC rate determination process.

(A) New FQHC.

(i) A new FQHC must file a projected cost report, pursuant to paragraph (8)(D) of this subsection, within 90 days of their designation as an FQHC to establish an initial interim base rate. The cost report must contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The initial interim base rate for a new FQHC shall be set at the lesser of eighty percent (80%) of the anticipated reasonable costs or eighty percent (80%) of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC or for a change in scope, if applicable.

(ii) Each new FQHC must submit to HHSC or its designee an As-Filed Medicare Cost Report, pursuant to paragraph (8)(A) of this subsection, within five (5) calendar months after the end of the FQHC's first full fiscal year. HHSC will determine an updated interim base rate based on one hundred percent (100%) of the reasonable costs contained in the As-Filed Medicare Cost Report. An As-Filed Medicare Cost Report must reflect twelve (12) months of continuous service that meets the requirements of paragraph (7)(B) of this subsection. Interim rates will be adjusted prospectively until the Final Audited Medicare Cost Report reflecting twelve (12) months of continuous service is processed. HHSC will, within eleven (11) months of receipt of the As-Filed Medicare Cost Report reflecting twelve (12) months of continuous service determine the updated interim base rate.

(iii) Each new FQHC must submit to HHSC or its designee a Final Audited Medicare Cost Report, pursuant to paragraph (9) of this subsection. The Final Audited Medicare Cost Report settlement, reflecting twelve (12) months of continuous service, must be completed within eleven (11) months of receipt of a cost report. The rate established shall be the final base rate. HHSC will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim base rate, HHSC will compute and pay the FQHC a settlement payment that represents the difference in rates for the services provided during the interim period. If the final base rate is less than the interim base rate, HHSC will compute and recoup from the FQHC any overpayment resulting from the difference in rates for the services provided during the interim period. The final base rate is adjusted in accordance with paragraph (4) of this subsection to determine the effective rate.

(iv) If a new FQHC cost report described in clause (ii) or (iii) of this subparagraph does not meet the requirement of reflecting twelve (12) months of continuous service that meets the requirements of paragraph (7)(B) of this subsection, HHSC will prospectively establish the interim rate based on the lesser of the interim rate determined by the cost report or eighty percent (80%) of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC or for a change in scope, if applicable, adjusted by applicable increases.

(B) Change of Ownership. If an existing FQHC facility changes ownership, the new owner must notify HHSC of the ownership change within ten (10) calendar days of the change.

(i) If the new owner of an FQHC facility owns no other FQHC facility in Texas, HHSC will treat the FQHC facility as a new FQHC. HHSC will set an initial interim base rate equal to one hundred percent (100%) of the previous owner's effective rate, and will then follow the procedures under subparagraph (A)(ii) and (iii) of this paragraph.

(ii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas and will include the new facility on the Medicare cost report of another FQHC facility, then HHSC will apply the rate assigned to the other FQHC.

(iii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas, but will not include the new facility on the Medicare cost report of another FQHC facility, then HHSC will determine a rate for the facility in accordance with clause (i) of this subparagraph.

(iv) If the new owner is ultimately not allowed by Medicare to include its new FQHC facility on the Medicare cost report of the other FQHC facility that it owns, then HHSC will determine a rate for the facility in accordance with subparagraph (A) of this paragraph.

(C) Request for Change of Effective Rate.

(i) An FQHC that requests an adjustment of its effective rate due to a change in scope or operating in an efficient manner must file a Change of Effective Rate Cost Report described in paragraph (8)(C) of this subsection. The FQHC must include the necessary documentation to support a claim that the FQHC has undergone a change in scope or is operating in an efficient manner pursuant to paragraph (7) of this subsection. A cost report filed to request an adjustment in the effective rate may be filed at any time during an FQHC's fiscal year, but no later than five (5) calendar months after the end of the FQHC's fiscal year. All requests for adjustment in the FQHC's effective rate must include at least six (6) months of financial data. Within sixty (60) days of receiving the Change of Effective Rate Cost Report described in paragraph (8)(C) of this subsection, HHSC or its designee will make a determination regarding a new interim base rate.

(ii) If HHSC determines through the review of the information provided in clause (i) of this subparagraph that an adjustment to the effective rate is warranted, HHSC will determine an interim base rate based on one hundred percent (100%) of the reasonable costs contained in the Change of Effective Rate Cost Report. Interim payments will be adjusted prospectively until the final audited cost report is processed.

(iii) The FQHC must submit to HHSC or its designee an As-Filed Medicare Cost Report, described in paragraph (8)(A) of this subsection, within five (5) calendar months after the end of the FQHC's fiscal year. HHSC and the FQHC will then follow the procedures under subparagraph (A)(ii) and (iii) of this paragraph.

(D) State Initiated Review.

(i) For an in-state FQHC that has chosen the APPS methodology, HHSC may prospectively reduce the FQHC's effective rate to reflect one hundred percent (100%) of its reasonable costs or the PPS effective rate, whichever is greater. After reviewing the Final Audited Medicare Cost Report described in paragraph (8)(B) of this subsection, HHSC will determine if an in-state FQHC is being reimbursed more than one hundred percent (100%) of its reasonable cost or the PPS effective rate, whichever is greater, through the following steps:

(I) Determine the reasonable cost per encounter from the Final Audited Medicare Cost Report;

(II) Determine the effective PPS rate per encounter as would have been applied to the FQHC if the FQHC had chosen PPS as described in subsection (a) of this section for the same time period corresponding to the FQHC's Final Audited Medicare Cost Report described in subclause (I) of this clause;

(III) Select the greater of subclause (I) or (II) of this clause;

(IV) If the result in subclause (III) of this clause is less than the APPS effective rate for this period, HHSC will set the result in subclause (III) of this clause as the new final base rate for this period;

(V) The prospective rate described in clause (iii) of this subparagraph will be determined by adjusting the new final base rate from subclause (IV) of this clause in accordance with paragraph (4) of this subsection to determine the effective rate.

(VI) The new final base rate from subclause (IV) of this clause and subsequent effective rates will not apply to claims for services provided prior to the implementation date described in clause (iii) of this subparagraph.

(ii) State initiated reviews will be based on a determined twelve (12) month time period and the most recent cost data received in accordance with paragraph (9) of this subsection. For any provider filing a Low Utilization Cost Report with Medicare in accordance with paragraph (9) of this subsection, upon request by HHSC, the provider must complete and submit the forms and worksheets described in paragraph (8)(A) of this subsection for the fiscal years ending within the determined twelve (12) month time period, even if the cost report was not required to be filed by Medicare.

(iii) HHSC will apply the state initiated rate reduction prospectively beginning on the first day of the month following forty-five (45) days after the date of the Final Base Rate Notification letter. The final base rate is adjusted in accordance with paragraph (4) of this subsection to determine the effective rate.

(iv) HHSC will not increase the effective rate for an FQHC based on the outcome of a state-initiated cost report audit. It is the responsibility of the FQHC to request HHSC to adjust the effective rate if the FQHC can show that it is operating in an efficient manner as defined in paragraph (7)(B) of this subsection, or can show a change in scope as defined in paragraph (7)(A) of this subsection.

(v) For PPS the state initiated reviews is not applicable, as described in subsection (a)(2) of this section.

(E) Final Base Rate Notification Letter. HHSC will provide to an FQHC written notification of any determined final base rate forty-five (45) days prior to implementation of the final base rate. The effective date of the final base rate is determined by the applicable FQHC Rate Determination Process described in subparagraph (A) - (D) of this paragraph.

(F) Request for Review of Final Base Rate. The FQHC may submit a written request for review of the final base rate within 30 days of the date of the Final Base Rate Notification Letter in the circumstances described in clauses (i) - (iii) of this subparagraph.

(i) The FQHC believes that HHSC made a mathematical error or data entry error in calculating the FQHC's reasonable cost. The request for review must include the supporting documentation of the perceived mathematical error or data entry error in calculating the final base rate. HHSC will evaluate the request for review and the merit of the supporting documentation. If HHSC determines the request for review merits a change in the final base rate, HHSC will

adjust the final base rate to the effective date of the Final Base Rate Notification Letter.

(ii) The FQHC believes that the FQHC made an error in reporting its cost or data in the Texas Medicaid Supplemental Worksheets described in paragraph (8)(A) of this subsection that would result in a different calculation of the FQHC's reasonable cost. The request for review must include the corrected Texas Medicaid Supplemental Worksheets and supporting documentation of the correction of error in reporting of cost or data. If HHSC determines the request for review merits a change in the final base rate, HHSC may adjust the final base rate to the effective date of the Final Base Rate Notification Letter.

(iii) The FQHC believes that the FQHC made an error in reporting its cost or data in the Final Audited Medicare Cost Report described in paragraph (8)(B) of this subsection that would result in a different calculation of the FQHC's reasonable cost. The request for review must include the correspondence submitted to the Medicare fiscal intermediary to amend the Medicare cost report. HHSC will consider the request for review upon receipt of the provider amended Final Audited Medicare Cost Report and supporting documentation of the correction of error in reporting of cost or data. If HHSC determines the request for review merits a change in the final base rate, HHSC may adjust the final base rate to the effective date of the Final Base Rate Notification Letter.

(iv) HHSC will send the FQHC written notification of the results of its request for review.

(v) If the FQHC disagrees with the results of the review in clause (iv) of this subparagraph, the FQHC may formally appeal in accordance with §§357.481 - 357.490 of this title (relating to Hearings Under the Administrative Procedure Act).

(11) In the event that the amount paid to an FQHC by a managed care organization (MCO) or dental managed care organization (DMO) is less than the amount the FQHC would receive under PPS or APPS, whichever is applicable, the state will ensure the FQHC is reimbursed the difference on at least a quarterly basis. The state's supplemental payment obligation will be determined by subtracting the baseline payment under the contract for services being provided from the effective PPS or APPS rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs, or bonuses.

(12) A visit is a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, a qualified clinical psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or an optometrist. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(B) the FQHC patient has a medical visit and an "other" health visit, as defined in paragraph (13) of this subsection.

(13) A medical visit is a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a qualified clinical psychologist, clinical social worker, other health professional for mental health services, a dentist, a dental hygienist, an optometrist, or a Texas Health Steps Medical Screen.

(c) Payment dispute.

(1) An FQHC that believes an MCO or DMO has improperly denied a claim for payment or has provided insufficient reimbursement may appeal to the MCO or DMO. The MCO or DMO must address provider appeals as required by Texas Government Code §540.0267 [~~§533.005(a)(15) and (19)~~] and its contractual obligations with HHSC.

(2) If the MCO or DMO is not able to resolve the appeal, the FQHC may submit a complaint to HHSC for review. If HHSC finds the MCO or DMO has not correctly reimbursed the FQHC in accordance with contractual obligations, HHSC may require the MCO or DMO to reimburse the FQHC and assess remedies against the MCO or DMO in accordance with HHSC's contract with the MCO or DMO.

(3) The state will ensure the FQHC is paid the full PPS or APPS encounter rate for all valid claims.

(4) This subsection applies to claims for services provided by an FQHC on an in-network or out-of-network 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 October 31, 2024.

TRD-202405202
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 221-9021

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

1 TAC §355.456

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.456, concerning Reimbursement Methodology.

BACKGROUND AND PURPOSE

The purpose of the proposal is to update the reimbursement methodology for the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) high medical needs add-on rates based on the Patient Driven Payment Model Long-Term Care (PDPM LTC) for nursing facilities. The current reimbursement methodology for ICF/IID high medical needs add-on is based on the Resource Utilization Group version 3 (RUG-III) classification system and associated costs. The 88th Legislature, Regular Session, 2023 directed HHSC to "develop and implement a Texas version of the Patient Driven Payment Model methodology for the reimbursement of long-term stay nursing facility services in the Medicaid program" according

to the 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 25). The PDPM LTC methodology implements a new nursing facility classification system for Medicaid residents. This amendment uses PDPM LTC classifications to establish the reimbursement methodology for the ICF/IID high medical needs add-ons.

SECTION-BY-SECTION SUMMARY

The amendment to §355.456(d) clarifies that the current high medical needs add-on reimbursement methodology in paragraph (6) applies before September 1, 2025, when the PDPM LTC methodology required under Rider 25 is anticipated to be implemented. New paragraph (7) establishes the revised high medical needs add-on methodology on or after September 1, 2025, using PDPM LTC nursing case-mix classifiers for each high medical needs add-on group. The amendment also removes subsection (j) related to the total Medicaid spending requirement as this provision is no longer applicable.

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 states economy.

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be an appropriate reimbursement methodology for ICF/IID high medical needs add-on based on patient-centered characteristics.

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 requirements on regulated persons.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030, or by email to PFD-LTSS@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 24R020" in the subject line.

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 by Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSCs 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.

§355.456. Reimbursement Methodology.

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

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

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

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

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

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

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

(6) High Medical Needs Add-on reimbursement rate before September 1, 2025. There is an available add-on reimbursement rate, in addition to the daily reimbursement rate, for certain individuals.

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

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

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

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

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

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

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

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

(iii) for residents of a large state-operated facility only, have a LON which includes a medical LON increase as described in 26 TAC §261.241 [~~40 TAC §9.241~~] (relating to Level of Need Criteria), but not be assessed a LON of pervasive plus.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Subtract the average nursing daily cost as specified in clause (ii) of this subparagraph from the median per diem amount of the nursing care rate component as specified in clause (iii)

of this subparagraph current recommended modeled rates as specified in subsection (d)(3) of this section.

(e) - (i) (No change.)

[(j) Total Medicaid Spending Requirement. Effective for costs and revenues accrued on or after September 1, 2015, through August 31, 2017, all non-state operated ICF/IID providers are required to spend at least 90 percent of revenues received through the ICF/IID daily Medicaid payment rates on Medicaid allowable costs under the ICF/IID program.]

[(1) Compliance with the total Medicaid spending requirement will be determined in the aggregate for all component codes controlled by the same entity across the ICF/IID, Home and Community-based Services (HCS), and Texas Home Living (TxHmL) programs within the same cost report year.]

[(2) Compliance with the spending requirement is determined on an annual basis using cost reports as described in Chapter 355, Subchapter A, of this title (relating to Cost Determination Process) and this subchapter.]

[(A) When a provider changes ownership through a contract assignment, the prior owner must submit a report covering the period from the beginning of the provider's fiscal year to the effective date of the contract assignment as determined by HHSC or its designee. This report is used as the basis for determining compliance with the spending requirement.]

[(B) Providers whose contracts are terminated voluntarily or involuntarily must submit a report covering the period from the beginning of the provider's fiscal year to the date recognized by HHSC or its designee as the contract termination date. This report is used as the basis for determining compliance with the spending requirement.]

[(C) When part of a cost reporting period is subject to spending accountability and part is not subject to spending accountability, a provider may choose to have HHSC divide their costs for the entire cost reporting period between the part of the period subject to spending accountability and the part of the period not subject to spending accountability on a pro-rata basis (i.e., pro-rata allocation). For example, if six months of a twelve month cost reporting period are subject to spending accountability, HHSC would divide the provider's costs for the entire cost reporting period by two to determine the costs subject to spending accountability. Providers who do not choose to have HHSC divide their costs on a pro-rata basis must report their costs for the period subject to spending accountability separately from their costs for the period not subject to spending accountability (i.e., direct reporting). Once a provider indicates to HHSC their choice between a pro-rata allocation and direct reporting for a specific cost reporting period, that choice is irrevocable for that cost reporting period.]

[(3) Allowable costs are those described in Chapter 355, Subchapter A, and this subchapter.]

[(4) The total Medicaid revenue for an ICF/IID provider participating in the attendant compensation rate enhancement is offset by any recoupment made under §355.112(s) of this title prior to determining compliance with the spending requirement.]

[(5) Providers who fail to meet the 90 percent spending requirement are subject to a recoupment of the difference between the 90 percent spending requirement and their actual Medicaid allowable ICF/IID costs. Recoupments for each rate period under this subsection are limited to the difference between the provider's Medicaid revenues for services provided at the rates subject to spending accountability and what the provider's Medicaid revenues would have been for services provided at the Medicaid rates in effect on August 31, 2015.]

[(6) The contracted provider, owner, or legal entity which received the Medicaid payment is responsible for the repayment of the recoupment amount. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification results in placement of a vendor hold on all HHSC and Texas Department of Aging and Disability Services contracts controlled by the responsible entity.]

[(7) Prior to each rate period through August 31, 2017, providers will be given the option of receiving the Medicaid rates adopted by HHSC for the rate period and the Medicaid rates that were in effect on August 31, 2015. Providers who chose to receive the Medicaid rates that were in effect on August 31, 2015, will not be subject to the spending accountability requirements described in this subsection.]

[(8) For rate periods beginning on or after September 1, 2017, the Total Medicaid Spending Requirement described in this subsection will no longer apply. Additionally, providers who chose to receive the Medicaid rates that were in effect on August 31, 2015, will receive the rates that were adopted effective September 1, 2015.]

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

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405233
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 867-7817

CHAPTER 357. HEARINGS
SUBCHAPTER L. FRAUD INVOLVING RECIPIENTS

1 TAC §357.562

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §357.562, concerning Determination and Disposition of Intentional Program Violations.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates references to existing laws.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to the existing law.

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 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 24R084" in the subject line.

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 Chapter 544.

The amendment affects Texas Government Code §531.0055 and Chapter 544.

§357.562. Determination and Disposition of Intentional Program Violations.

(a) The Texas Department of Human Services (DHS) determines the existence of intentional program violations; refers cases for investigation, administrative hearings, and prosecution; takes collection action and ensures clients' rights according to applicable Texas criminal statutes and the following:

(1) Temporary Assistance for Needy Families (TANF)--as provided in:

(A) Personal Responsibility and Work Opportunity Act (42 U.S.C. §601 et. seq.);

(B) Human Resources Code, Chapter 31; and

(C) Texas Government Code Chapter 544, Subchapter I [~~Government Code, §531.114~~];

(2) Food Stamp Program--7 Code of Federal Regulations, §§273.16 - 273.18; and

(3) Medicaid Program--42 Code of Federal Regulations, §455.2 and §455.16.

(b) Individuals found to have committed an intentional program violation in the food stamp and/or TANF programs through an administrative disqualification hearing or who have signed a waiver of right to an administrative disqualification hearing are subject to the disqualification periods outlined in §79.1917 of this title (relating to Effect of an Administrative Determination of Intentional Program Violation).

(c) If a person is convicted of a state or federal offense for conduct, as described in §79.2001(c) of this title (relating to Terms and General Policy), and such conduct is committed on or after September 1, 2003, or if the person is granted deferred adjudication or placed on community supervision for that conduct, the person is permanently disqualified from receiving financial assistance.

(d) Individuals found to have committed an intentional program violation in the Food Stamp Program by a court of appropriate jurisdiction, or on the basis of a plea of nolo contendere or otherwise in cases referred for prosecution in state or federal court, are subject to the disqualification periods outlined in §79.1917(a) of this title.

(e) In TANF cases, DHS does not take the needs of the disqualified individual into account during the period he is disqualified when determining the assistance unit's need and amount of assistance. DHS

considers any resources and income of the disqualified individual as available to the assistance unit. DHS does not disqualify an individual from the TANF program unless the overissuance of benefits resulting from the intentional violation occurred in the month of October 1988 or later.

(f) Disqualified individuals are ineligible for TANF Medicaid benefits during the disqualification period. However, they may qualify for and receive benefits under provisions of Chapter 2 of this title (relating to Medically Needy and Children and Pregnant Women Programs).

(g) A household member may be charged with an intentional program violation even if he has not actually received benefits to which he is not entitled.

(h) The amount of the intentional program violation claim must be calculated back to the month the act of intentional program violation occurred, regardless of the length of time that elapsed until the determination of intentional program violation was made. However, DHS must not include in its calculation any amount of the overissuance that occurred in a month more than six years from the date the overissuance was discovered for food stamp cases.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 221-9021

CHAPTER 360. MEDICAID BUY-IN PROGRAM

1 TAC §360.101

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §360.101, concerning Overview and Purpose.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates a reference to existing law.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to the existing law.

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 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 24R084" in the subject line.

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 Chapter 532.

The amendment affects Texas Government Code §531.0055 and Chapter 532.

§360.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for the Medicaid Buy-In Program (MBI), which is authorized under Texas Government Code §532.0353 [~~§531.02444 of the Texas Government Code~~], and which provides Medicaid benefits under the option explained in §1902(a)(10)(A)(ii)(XIII) of the Social Security Act (42 U.S.C. §1396a(a)(10)(A)(ii)(XIII)). All references in this chapter to MBI mean the Medicaid Buy-In Program.

(b) MBI is administered by the Texas Health and Human Services Commission (HHSC). All references in this chapter to HHSC mean the Texas Health and Human Services Commission.

(c) MBI provides Medicaid benefits to working persons with disabilities, regardless of age, who apply for Medicaid and meet the requirements explained in this chapter.

(d) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

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 October 31, 2024.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 221-9021

CHAPTER 361. MEDICAID BUY-IN FOR CHILDREN PROGRAM

1 TAC §361.101

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §361.101, concerning Overview and Purpose.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates a reference to existing law.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to the existing law.

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 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 24R084" in the subject line.

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 Chapter 532.

The amendment affects Texas Government Code §531.0055 and Chapter 532.

§361.101. Overview and Purpose.

(a) This chapter governs the eligibility requirements for Medicaid Buy-In for Children (MBIC), which is authorized under Texas Government Code §532.0353 [~~§531.02444 of the Texas Government Code~~]. MBIC provides Medicaid benefits under the option explained in §1902(cc) of the Social Security Act (42 U.S.C. §1396a(cc)).

(b) MBIC is a Medicaid buy-in program for children with disabilities administered by the Texas Health and Human Services Commission (HHSC). It provides Medicaid benefits to eligible children with disabilities who are not eligible for Supplemental Security Income (SSI) for reasons other than disability. A child does not have to have applied for SSI in order to meet eligibility requirements for MBIC.

(c) Nothing in these rules shall be construed to violate the maintenance of eligibility requirements of section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) and make eligibility standards, methodologies, or procedures under the Texas State Plan for Medical Assistance (or any waiver under section 1115 of the Social Security Act (42 U.S.C. §1315)) more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that were in effect on July 1, 2008.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 221-9021

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CHAPTER 370. STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SUBCHAPTER F. SPECIAL INVESTIGATIVE UNITS

1 TAC §370.501

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §370.501, concerning Purpose.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates a reference to existing law.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to the existing law.

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 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 24R084" in the subject line.

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 Chapter 544.

The amendment affects Texas Government Code §531.0055 and Chapter 544.

§370.501. Purpose.

(a) This subchapter implements the Health and Human Services Commission's (HHSC), Office of Inspector General (OIG) authority to approve annually, each managed care organization (MCO) plan to prevent and reduce waste, abuse, and fraud. This authority is granted by Texas Government Code §544.0353 [~~Chapter 531, Subchapter C, Government Code, §531.113~~].

(b) An MCO that provides or arranges for the provision of health care services or dental services to an individual under the children's health insurance program (CHIP), must arrange for a special investigative unit to investigate fraudulent claims and other types of program abuse by recipients and providers. An MCO may choose to:

(1) establish and maintain the special investigative unit within the MCO; or

(2) contract with another entity for the investigation.

(c) An MCO must:

(1) develop a plan to prevent and reduce waste, abuse, and fraud;

(2) submit the plan annually to the HHSC-OIG for approval each year the MCO is enrolled with the State of Texas; and

(3) submit the plan 90 days before the start of the State fiscal year.

(d) If HHSC-OIG does not approve the initial plan to prevent and reduce waste, abuse, and fraud, the MCO must resubmit the plan to HHSC-OIG within 15 working days of receiving the denial letter, which will explain the deficiencies. If the plan is not resubmitted within the time allotted, the MCO will be in default and remedies or sanctions may be imposed.

(e) If the MCO elects to contract with another entity for the investigation of fraudulent claims and other types of program abuse as referenced in subsection (b)(2) of this section, the MCO must adhere to all requirements of Title 42, §438.230 of the Code of Federal Regulations.

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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CHAPTER 380. MEDICAL TRANSPORTATION PROGRAM

SUBCHAPTER A. PROGRAM OVERVIEW

1 TAC §380.101

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §380.101, concerning Definitions.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates a reference to existing law.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to the existing law.

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 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 24R084" in the subject line.

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 Chapter 526.

The amendment affects Texas Government Code §531.0055 and Chapter 526.

§380.101. Definitions of Terms.

The following words and terms are applicable to this Chapter, Medical Transportation Program (MTP):

(1) Abuse--The willful infliction of intimidation or injury resulting in physical harm, pain, or mental anguish.

(2) Accident--An unexpected event or series of events causing loss or injury to person or property (e.g., automobile).

(3) Adjacent county(ies)--The county or counties that share a common county line or point with the client's county of residence.

(4) Advance funds--Funds authorized in advance of travel and provided to the client or attendant to cover authorized transportation services (e.g., gas money, lodging, and/or meals) for travel to a covered health care service.

(5) Ambulance service--A service paid through HHSC or its designee in an emergency, or non-emergency situation in which transportation in a vehicle other than an ambulance could endanger the recipient's health.

(6) Attendant--

(A) an adult required to accompany a prior authorized MTP client under §380.207(4) of this chapter (relating to Program Limitations);

(B) an adult that accompanies a prior authorized MTP client to provide necessary mobility, personal or language assistance to the client during the time that transportation services are provided;

(C) a service animal that accompanies a prior authorized MTP client to provide necessary mobility or personal assistance to the client during the time that transportation services are provided; or

(D) an adult that accompanies a prior authorized MTP client because a health care provider has submitted a statement of need that the client requires an attendant.

(7) Certification Period--A period of time for which a Transportation for Indigent Cancer Patient client is certified for service.

(8) Children with Special Health Care Needs (CSHCN) services program--A program funded with general revenue and federal funds administered by the Department of State Health Services. Services for eligible children include early identification, diagnosis and evaluation, resulting in early health care intervention.

(9) Covered health care service--A service included in the premium of the health care policy paid by or on behalf of an MTP client.

(10) Demand Response--Transportation that involves using performing provider dispatched vehicles in response to requests from clients or shared one-way trips.

(11) Health and Human Services Commission (HHSC)--The state agency that operates the Medical Transportation Program.

(12) Health Care Provider's Statement of Need--MTP Form 3113 or equivalent submitted by a health care provider which documents the client's need for health care services and/or special transportation accommodations.

(13) Individual Transportation Participant (ITP)--An individual who has been approved for mileage reimbursement at a rate prescribed by HHSC to provide transportation for a prior authorized MTP client to a covered health care service.

(14) Limited Status--A Medicaid client's limitation to a designated provider, either a primary care provider or primary care pharmacy, under the lock-in provisions contained in Chapter 354, Subchapter K of this title (relating to Medicaid Recipient Utilization Review and Control). Clients are limited for specific periods of time as outlined in §354.2405(c) of this title (relating to Utilization Control).

(15) Lodging--A commercial establishment such as a hotel, motel, charitable home or hospital that provides overnight lodging.

(16) Long Distance Trip--Transportation beyond a county adjacent to a client's county of residence or Medicaid managed care service delivery area for the purpose of receiving a covered health care service.

(17) Managed Transportation Organization (MTO)--

(A) a rural or urban transit district created under Chapter 458, Transportation Code;

(B) a public transportation provider defined by §461.002, Transportation Code;

(C) a regional contracted broker defined by Texas Government Code §526.0351 [~~Government Code §531.02414~~];

(D) a local private transportation provider approved by HHSC to provide MTP services; or

(E) any other entity HHSC determines meets the requirements.

(18) Mass transit--Public transportation by bus, rail, air, ferry, or intra-city bus either publicly or privately owned, which provides general or special service transportation to the public on a regular and continuing basis. Mass transit is intercity or intra-city transportation and also includes the use of commercial air service to transport clients to an authorized service.

(19) Medicaid--A health care program provided to eligible individuals under 42 U.S.C. §1396a *et seq.;* 42 C.F.R. §431.53; Texas Human Resources Code, Chapters 22 and 32.

(20) Medically necessary--Services that are:

(A) reasonably necessary to: prevent illness(es) or medical condition(s); maintain function or to slow further functional deterioration; provide early screening, intervention, care, and/or provide care or treatment for eligible clients who have medical condition(s) that cause suffering or pain, physical deformity or limitations in function, or that threaten to cause or worsen a disability, illness or infirmity, or endanger life;

(B) provided at appropriate locations and at the appropriate levels of care for the treatment of the medical condition(s);

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

(D) consistent with the diagnosis(es) of the condition(s);

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

(F) not experimental or investigative; and

(G) not primarily for the convenience of the client.

(21) Medical Transportation Program (MTP)--The program that provides prior authorized nonemergency transportation services to and from covered health care services, based on medical necessity, for categorically eligible Medicaid clients enrolled in Medicaid, and eligible clients enrolled in CSHCN services program, or the Transportation for Indigent Cancer Patients program who have no other means of transportation.

(22) Minor--An individual under 18 years of age who has never been married or emancipated by court ruling.

(23) Passenger assistance--Transportation from curb at origin to curb at destination, including providing assistance, as required, to clients entering and exiting the vehicle.

(24) Performing provider--An entity that arranges or provides transportation services to a prior authorized MTP client, including subcontractors, independent contractors, lodging and meal vendors, and intercity or intra-city bus services.

(25) Prior authorization--Authorization or approval for the provision of transportation services obtained from MTP or a transportation provider before the services are rendered.

(26) Prior authorized MTP client--A client authorized by HHSC as eligible for Medicaid services under a specific category, or identified by either the CSHCN service program or the TICP program as eligible for program services, who has no other means of transportation to covered health care services.

(27) Reasonable transportation--Transportation using the most cost-effective transportation that meets the client's medical needs:

(A) within a client's local community, county of residence, or county adjacent to a client's county of residence where the client wishes to maintain an ongoing relationship or establish a relationship with a health care provider of his or her choice; or

(B) to a provider or facility within a designated Medicaid managed care service delivery area.

(28) Regional contracted broker--An entity that contracts with HHSC to provide or arrange for the provision of nonemergency transportation services under the MTP, including a full risk broker as referenced in 42 C.F.R. §440.170(a)(4) (relating to nonemergency medical transportation brokerage program).

(29) Routine medical transportation--Prior authorized medical transportation trips, other than long distance trips, to and/or from a facility where covered health care services will be provided.

(30) Service animal--A trained guide dog, signal dog, or other animal to provide assistance to a specified MTP client with a disability.

(31) Sexual harassment--Unwelcome sexual advances, requests for sexual favors, or other unwanted verbal or physical conduct of a sexual nature directed toward an individual by another individual during the provision of transportation services.

(32) Significant traditional provider--An individual or entity that has a documented record of providing transportation services for a minimum of two years.

(33) Special needs--A transportation service that requires the use of a vehicle equipped with a ramp or a mechanical lift to provide the client with a means of accessing the vehicle.

(34) Transportation provider--A regional contracted broker or an MTO.

(35) Transportation for Indigent Cancer Patients (TICP) Program--A state-funded program that provides medical transportation services to individuals diagnosed with cancer or a cancer-related illness and who meet residency and financial criteria.

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 October 31, 2024.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 221-9021

CHAPTER 391. PURCHASE OF GOODS AND SERVICES BY THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER B. PROCUREMENT AND SPECIAL CONTRACTING METHODS

DIVISION 2. SPECIAL CONTRACTING METHODS

1 TAC §391.247

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §391.247, concerning Direct Contract Award.

BACKGROUND AND PURPOSE

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

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendments only update references to existing laws.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates references to existing laws.

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 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 24R084" in the subject line.

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 Chapter 544.

The amendment affects Texas Government Code §531.0055 and Chapter 544.

§391.247. Direct Contract Award.

(a) Texas HHSC Office of Inspector General (OIG) direct contract award. If HHS does not receive any responsive proposals on a competitive solicitation for the services of a qualified expert to review investigative findings under Texas Government Code §544.0104(b) or §544.0105(b) [~~§531.102(l) or §531.102(m)~~], HHS may instead award contracts that are not subject to competitive advertising and proposal evaluation requirements. HHS may negotiate with and award a contract to a qualified expert based on:

(1) the contractor's agreement to set a fee (range or lump-sum); and

(2) the contractor's affirmation and the OIG's verification that the contractor has the necessary occupational licenses and experience.

(b) OIG direct contract awards not subject to competitive advertising. In accordance with Texas Government Code §544.0106(b) [~~§531.102(m-1) and §531.102(m-2)~~], and notwithstanding Texas Government Code §2155.083 and §2261.051, a contract awarded under subsection (a) of this section is not subject to competitive advertising and proposal evaluation requirements.

(c) HHSC state operated facilities direct contract award. If HHSC does not receive any responsive competitive bids or proposals in response to a solicitation for goods or services for a state hospital or a state supported living center as defined by Texas Health and Safety Code §531.002, HHSC, after the procurement director makes a written determination that competition is not available, may negotiate with and award a contract to any qualified vendor who meets the requirements of the original solicitation. The contract must be at current market value price and the term may not exceed five years.

(d) Direct contract award for professional services of physicians, optometrists, and registered nurses. If procuring services in connection with professional employment or practice of a physician, optometrist, or registered nurse as defined by Texas Government Code §2254.002(2)(B)(v), (vi), or (ix) and the number of contracts is not otherwise limited, HHS, DFPS, and TCCO may make the selection and award based on:

(1) the provider's agreement to a set fee, as a range or lump sum amount; and

(2) the provider's affirmation and the HHS, DFPS, or TCCO's verification that the provider has the necessary occupational licenses and experience.

(e) Professional services for physicians, optometrists, and registered nurses not subject to competitive advertising. In accordance with Texas Government Code §2254.008, and notwithstanding Texas Government Code §2155.083 and §2261.051, a contract awarded under subsection (d) of this section is not subject to competitive advertising and proposal evaluation requirements.

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 395. CIVIL RIGHTS
SUBCHAPTER A. GENERAL PROVISIONS
1 TAC §395.2

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §395.2, concerning Definitions.

BACKGROUND AND PURPOSE

House Bill 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social

services as part of the legislature's ongoing statutory revision program. This proposal is necessary to update citations in the rules to Texas Government Code sections that become effective on April 1, 2025. The proposed amendment updates the affected citation to the Texas Government Code.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule because the amendment only updates a reference to existing law.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Libby Elliott, Deputy Executive Commissioner, Office of Policy and Rules, has determined that for each year of the first five years the rule is in effect, the public will benefit from rules that accurately cite the laws governing HHSC, Medicaid, and other social services.

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 amendment only updates a reference to existing law.

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 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 24R084" in the subject line.

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 Chapter 521.

The amendment affects Texas Government Code §531.0055 and Chapter 521.

§395.2. Definitions.

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

(1) Applicant--A person who applies in writing, electronically, orally, or through a designated representative to participate in a program funded, in whole or in part, by an HHS agency.

(2) Complainant--A person who alleges discrimination in access to or the delivery of program services or benefits funded, in whole or in part, by an HHS agency on the basis of race, color, national origin, age, sex, disability, religion, or political belief. (Not all bases apply to all programs.) Political belief is considered a protected class only in the Supplemental Nutrition Assistance Program (SNAP). Other groups may be added as protected classes pursuant to applicable federal or state statutes or rules.

(3) Complaint--An oral or written allegation of discrimination or retaliation made by a complainant.

(4) Contractor--An entity that contracts or agrees through other arrangements with a state agency to provide services or benefits on behalf of an HHS agency. This includes any subcontractor that provides services or benefits on behalf of an HHS agency.

(5) Discrimination--Treatment of an individual that is based on his or her membership in a legally protected class and that has an adverse effect on the individual.

(6) Electronic and information resources (EIR)--Information technology and any equipment or interconnected system or subsystem of equipment that is used in the creation, conversion, or duplication of data or information. EIR includes telecommunication prod-

ucts, information kiosks, transaction machines, websites, multimedia, and office equipment.

(7) HHS agency--The Texas Health and Human Services Commission and the Texas health and human services agencies identified in Government Code §521.0001 [~~§531.001(4)~~].

(8) HHSC--The Texas Health and Human Services Commission.

(9) HHSC Civil Rights Office (CRO)--The functional area within HHSC responsible for ensuring that the HHS agencies comply with applicable state and federal civil rights laws and regulations as well as HHSC's civil rights policies and procedures.

(10) Limited English proficiency (LEP)--A term describing individuals who do not speak English as their primary language and who have limited ability to read, speak, write, or understand English.

(11) Participant--An individual who receives assistance, services, or benefits under any HHS agency program or service.

(12) Protected class--A group or class of persons having a characteristic, quality, belief, or status defined by federal and state civil rights laws and regulations as protected from discrimination. Protected classes or groups, which differ between programs, include race, color, national origin, sex, age, religion, or disability, and may include political belief. Political belief is considered a protected class only in SNAP. Veteran status is a protected class only as to employment-related complaints pursuant to state and federal law. Other groups may be added as protected classes pursuant to applicable federal or state statute or rules.

(13) Retaliation--Adverse treatment of an individual because he or she filed a complaint, participated in the complaint process, or otherwise opposed discriminatory practices.

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 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 1. LIBRARY DEVELOPMENT

SUBCHAPTER C. MINIMUM STANDARDS FOR ACCREDITATION OF LIBRARIES IN THE STATE LIBRARY SYSTEM

13 TAC §§1.71 - 1.75, 1.77, 1.79 - 1.87

The Texas State Library and Archives Commission (commission) proposes the repeal of Texas Administrative Code, Title 13, Chapter 1, Subchapter C, 13 TAC §§1.71 - 1.75, 1.77 and 1.79 - 1.87, concerning Minimum Standards for Accreditation of Libraries in the State Library System. This repeal will enable the commission to update the accreditation standards for public libraries seeking accreditation for State Fiscal Year 2028.

BACKGROUND. Government Code, Chapter 441, Subchapter I, Library Systems, authorizes the commission to establish criteria a library must meet for accreditation. The commission adopted these accreditation standards at 13 Texas Administrative Code, Chapter 1, Subchapter C, Minimum Standards for Accreditation of Libraries in the State Library System, §§1.71 - 1.87. These rules set forth in detail the requirements for any public library seeking accreditation. Accreditation is not a requirement for public libraries in Texas. However, accredited libraries are eligible to participate in statewide interlibrary loan (ILL), apply for E-rate (a federal telecommunications discount program) and a variety of funding opportunities offered by the commission throughout the year, and take advantage of the TexShare Card and TexShare Databases programs through membership in the TexShare Consortium.

To become accredited or maintain accreditation, public libraries must submit an annual report to the commission demonstrating they have met each of the accreditation criteria. Each annual report includes information from the preceding local fiscal year and is due during the calendar year following the conclusion of the local fiscal year. If approved, the public library will then be accredited for the next state fiscal year. The current accreditation standards cover local fiscal years 2013 through 2025. Information from local fiscal year 2025 will be reported during spring of 2026 for accreditation for state fiscal year 2027. Therefore, to provide for continued accreditation beyond state fiscal year 2027, the commission must update the existing standards.

The commission began reviewing the accreditation rules for necessary updates and improvements in May 2023. The Library Systems Act Advisory Board considered the rules and needed updates on March 14, 2024. Commission staff hosted a series of eight sessions to review and discuss the proposed revisions, with nearly 380 librarians attending from all over the state. Following these sessions, commission staff incorporated feedback and drafted proposed revisions to the standards. The full commission discussed these proposed revisions at the June 7, 2024, and August 2, 2024, commission meetings. The commission's Libraries and Talking Book Committee also discussed the revisions at the July 11, 2024, committee meeting.

The commission is now proposing new accreditation standards to replace the existing accreditation standards. While some of the existing language in the accreditation standards will remain unchanged in the proposed new accreditation standards, the commission is proposing a significant number of revisions as well as proposing new sections. Therefore, the commission has determined the best approach is to repeal the existing sections and replace those sections with the proposed new sections. The proposed new sections may also be found in this issue of the *Texas Register.*

FISCAL IMPACT. Sarah Karnes, Division Director, Library Development and Networking Division, has determined that for each of the first five years the proposed repeals are in effect, there will be no reasonably foreseeable fiscal implications for the state or local governments. Accreditation is not mandatory for a library to operate as a public library. Accreditation is an optional status that libraries may achieve if they wish to take advantage of certain agency programs and services.

PUBLIC BENEFIT AND COSTS. Ms. Karnes has determined that for each of the first five years the proposed repeals are in effect, the anticipated public benefit will be clarity in the process for accreditation of public libraries based on criteria that update economic indicators, modernize technology requirements, and integrate provisions for enhanced public transparency, including delineating policies the library must maintain. Updating and improving the language of the rules will also ensure libraries better understand the accreditation process, leading to more libraries reporting and seeking accreditation. Members of the public would, therefore, benefit from increased access to additional services, programs, and opportunities provided by the library, such as internet access (available to accredited libraries at a discount through the federal E-Rate Program) and an enhanced collection (through the statewide interlibrary loan program).

There are no anticipated economic costs to persons required to comply with the proposed repeals, as accreditation is not required for public libraries.

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

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT STATEMENT. There will be no adverse economic effect on small businesses, micro-businesses, or rural communities; therefore, a regulatory flexibility analysis under Government Code, §2006.002 is not required.

COST INCREASE TO REGULATED PERSONS. The rules as proposed for repeal do not impose or increase a cost on regulated persons, including another state agency, a special district, or a local government. Therefore, the commission is not required to take any further action under Government Code, §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. In compliance with Government Code, §2001.0221, the commission provides the following government growth impact statement. For each year of the first five years the rules as proposed for repeal will be in effect, the commission has determined the following:

1. The proposed repeals will not create or eliminate a government program;

2. Implementation of the rules as proposed for repeal will not require the creation of new employee positions or the elimination of existing employee positions;

3. Implementation of the rules as proposed for repeal will not require an increase or decrease in future legislative appropriations to the commission;

4. The proposal will not require an increase or decrease in fees paid to the commission;

5. The proposal will not create new regulations;

6. The proposal will repeal existing regulations;

7. The proposal will not increase the number of individuals subject to the proposed rules' applicability; and

8. The proposal will not positively or adversely affect the state's economy.

TAKINGS IMPACT ASSESSMENT. No private real property interests are affected by this proposal, and 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. Therefore, the proposed rules do not constitute a taking under Government Code, §2007.043.

REQUEST FOR PUBLIC COMMENT. Written comments on the proposed repeals may be submitted to Sarah Swanson, General Counsel, Texas State Library and Archives Commission, P.O. Box 12927, Austin, Texas 78711, or via email at rules@tsl.texas.gov. To be considered, a written comment must be received no later than 45 days from the date of publication in the *Texas Register.*

STATUTORY AUTHORITY. The repeals are proposed under Government Code, §441.135, which authorizes the commission to adopt guidelines for the awarding of grants; §441.136, which authorizes the commission to adopt rules necessary to the administration of the program of state grants, including qualifications for major resource system membership; §441.127, which provides that to be eligible for membership in a major resource system or regional library system, a library must meet the accreditation standards established by the commission; and §441.122(1) and (2), which defines "accreditation of libraries" as the evaluation and rating of libraries according to commission accreditation standards and "accreditation standards" as the criteria established by the commission that a library must meet to be accredited and eligible for membership in a major resource system.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

§1.71. Definition of Population Served.
§1.72. Public Library Service.
§1.73. Public Library: Legal Establishment.
§1.74. Local Operating Expenditures.
§1.75. Nondiscrimination.
§1.77. Public Library: Local Government Support.
§1.79. Provisional Accreditation of Library.
§1.80. Probational Accreditation of Library.
§1.81. Quantitative Standards for Accreditation of Library.
§1.82. Accreditation Based on Current Operating Budget.
§1.83. Other Requirements.
§1.84. Professional Librarian.
§1.85. Annual Report
§1.86. Standards for Accreditation of Libraries Operated by Public School Districts, Institutions of Higher Education, Units of Local, State, or Federal Government, Accredited Non-Public Elementary or Secondary Schools, or Special or Research Libraries.
§1.87. Emergency Waiver of Accreditation Criteria.

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

Filed with the Office of the Secretary of State on November 4, 2024.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 463-5460

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13 TAC §§1.70 - 1.82

The Texas State Library and Archives Commission (commission) proposes new Texas Administrative Code, Title 13, Chapter 1, Subchapter C, §1.70, Purpose and Scope; §1.71, Definitions; §1.72, Legal Service Area; §1.73, Public Library Services; §1.74, Public Library: Legal Establishment; §1.75, Local Operating Expenditures; §1.76, Quantitative Standards for Accreditation of a Library; §1.77, Other Operational Requirements; §1.78, Annual Report; §1.79, Emergency Waiver of Accreditation Criteria; §1.80, Conditional Accreditation of Library; §1.81, Loss of Accreditation; and §1.82, Appeal of Accreditation Determination.

BACKGROUND. Government Code, Chapter 441, Subchapter I, Library Systems, authorizes the commission to establish criteria a library must meet for accreditation. The commission adopted these accreditation standards at 13 Texas Administrative Code, Chapter 1, Subchapter C, Minimum Standards for Accreditation of Libraries in the State Library System, §§1.71 - 1.87. These rules set forth in detail the requirements for any public library seeking accreditation. Accreditation is not a requirement for public libraries in Texas. However, accredited libraries are eligible to participate in statewide interlibrary loan (ILL), apply for E-rate (a federal telecommunications discount program) and a variety of funding opportunities offered by the commission throughout the year, and take advantage of the TexShare Card and TexShare Databases programs through membership in the TexShare Consortium.

The accreditation of a public library serves an important public function. Accreditation provides an official designation demonstrating that a public library complies with a statewide framework for accountability, minimal operational and financial standards, public transparency, and service requirements. This demonstration benefits the public's interest and serves the community by providing an important means for the library to demonstrate to potential financial supporters or program partners a library's recognized standing.

To become accredited or maintain accreditation, public libraries must submit an annual report to the commission demonstrating they have met each of the accreditation criteria. Each annual report includes information from the preceding local fiscal year and is due during the calendar year following the conclusion of the local fiscal year. If all accreditation criteria are met, the public library will then be accredited for the next state fiscal year. The current accreditation standards cover local fiscal years 2013 through 2025. Information from local fiscal year 2025 will be reported during spring of 2026 for accreditation for state fiscal year 2027. Therefore, to provide for continued accreditation beyond state fiscal year 2027, the commission must update the existing standards.

The commission began reviewing the accreditation rules for necessary updates and improvements in May 2023. The Library Systems Act Advisory Board considered the standards and needed updates on March 14, 2024. Commission staff hosted a series of eight sessions with stakeholders in May 2024 to review and discuss proposed revisions, with nearly 380 librarians attending from all over the state. Following these sessions, commission staff incorporated feedback and drafted proposed revisions to the standards. The full commission discussed these proposed revisions at the June 7, 2024, and August 2, 2024, commission meetings. The commission's Libraries and Talking Book Committee also discussed the revisions at the July 11, 2024, committee meeting.

The commission is now proposing new accreditation standards to replace the existing accreditation standards. While some of the existing language in the accreditation standards will remain unchanged in the proposed new accreditation standards, the commission is proposing a significant number of revisions as well as proposing new sections. Therefore, the commission has determined the best approach is to repeal the existing sections and replace those sections with the proposed new sections. The proposed repeals may also be found in this issue of the *Texas Register*. The proposed repeals and new sections will not become effective until September 1, 2025, but are being published now to ensure public libraries have an ability to plan for the new accreditation criteria and associated processes.

EXPLANATION OF PROPOSED NEW SECTIONS.

Proposed new §1.70, Purpose and Scope, establishes the commission's responsibilities related to accreditation and describes the purpose and scope of the new subchapter. The proposed new section also clarifies that accreditation is designed to establish the minimum criteria a library must meet to take advantage of certain programs offered by the commission. It is not intended to evaluate the adequacy of a public library's staff, budget, resources, or services, and is not intended to limit or restrict the number of communities in Texas that wish to operate a public library. The new section would also clarify that the annual report described in proposed new §1.78 (relating to Annual Report) is the mechanism by which accreditation criteria are reviewed and accreditation is awarded.

Proposed new §1.71, Definitions, would define terms used throughout the subchapter, including accreditation, agency, commission, continuing education, library collection item, library operating hours, local fiscal year, per capita, professional librarian, public library, and state fiscal year. Including a definitions section will simplify rule language throughout the subchapter.

Proposed new §1.72, Legal Service Area, is a revision of previous §1.71, Definition of Population Served. Proposed revisions update the language for clarity, including new language noting that a public library's legal service area is based on the source(s) of local government funding for the library and the population assigned according to the rule. Other revisions to the previous rule language add municipalities to the rule language to ensure all potential local communities are addressed and update how population is assigned to a library when a school district contracts with another entity for public library services as part of their students' educational program. Previous §1.71(7) provided that the commission would estimate the total population living within the school district. New §1.72(a)(7) would credit the library with serving the population living within the school district as published annually by the most recent Small Area Income and Poverty Estimate Program (SAIPE). Another proposed revision would delete previous §1.71(9), which related to libraries in areas where the population of a federal or state eleemosynary or correctional institution or military installation exceeds 10% of the entire population. The commission has found that this subparagraph is not necessary because these populations are generally part of separate statewide systems to provide library purposes. Therefore, the populations should not be included for public library services.

Proposed new §1.73, Public Library Services, is a new section that would clarify what services a public library must provide to the general public without charge regardless of the person's residency; what services a public library may provide at a charge to any member of the public regardless of the person's residency; and what services a library must provide at no charge to members of the public who reside in the library's legal service area but may provide at a charge to nonresidents. New subsection (b)

would apply to library entities contracted with school districts to provide library services to the general public and notes that those libraries must meet any policy requirements for K-12 school environments in addition to the public library requirements. New subsection (f) would require a public library to certify annually that no person shall be excluded from participation in or denied the benefits of the appropriate services of that library in accordance with federal law, a requirement previously codified in §1.75 (relating to Nondiscrimination).

Proposed new §1.74, Public Library: Legal Establishment, is a revision of previous §1.73 (relating to Public Library: Legal Establishment). Proposed revisions to the section update and clarify the language.

Proposed new §1.75, Local Operating Expenditures, is a revision of previous §1.74 (relating to Local Operating Expenditures). Proposed revisions would add a new subsection requiring that at least half of the annual local operating expenditures required to meet the minimum level of per capita support for accreditation be from local government sources. Proposed revisions would increase total local expenditures to at least $24,000 in local fiscal years 2026, 2027, and 2028; at least $27,000 in local fiscal years 2029, 2030, and 2031, and at least $30,000 in local fiscal years 2032, 2033, and 2034. These adjustments are consistent with previous increases and represent a three percent growth from previous minimum total local expenditures. The commission has reviewed the local operating expenditures of libraries that are currently accredited and those that are not currently accredited and determined that the proposed increases should not be difficult for any library to meet. Additional revisions to this section would exempt a library from these accreditation criterion if it expends at least $22.00 per capita and either shows evidence that it is open to the public under identical conditions without charge or that it expends at least $200,000 of local funds.

Proposed new §1.76, Quantitative Standards for Accreditation of a Library, is a revision of previous §1.81, Quantitative Standards for Accreditation of Library. Proposed revisions would add a subsection clarifying that a public library must meet the quantitative standards for accreditation in addition to the other requirements of the subchapter. Proposed revisions would also restructure and simplify the section, grouping standards applicable to all libraries together rather than repeating standards multiple times throughout the rule. New subsection (b) would require a public library to have at least one library collection item per capita or expend at least 15% of the library's local expenditures on library collection items, unless the library serves 25,000 persons or less, in which case the library must maintain a collection of at least 7,500 library collection items. New subsection (c) would require that at least 5% of a public library's library collection items be published or created in the last five years. New subsection (d) would require that a public library be open for service not less than 40 hours per week, unless the library services 25,000 persons or less, in which case it must be open for not less than 20 hours per week. New subsection (e) would require that a public library employ a library director for at least 40 hours per week, unless the library serves 25,000 persons or less, in which case the library must employ a library director for at least 20 hours per week. New subsection (f) would establish minimum required hours of annual continuing education for library directors. New subsection (g) would establish minimum local expenditures per fiscal year based on the population served by the library. The previous rule included eight population ranges: at least 500,001 persons; 200,001 - 500,000 persons; 100,001 - 200,000 persons; 50,001 - 100,000 persons; 25,001 - 50,000 persons; 10,001 - 25,000 persons; 5,001 - 10,000 persons; and 5,000 or fewer persons. The proposed new section would consolidate and simplify the ranges and local expenditures as follows: 200,001 persons or more; 100,001 - 200,000 persons; 25,001 - 100,000 persons; and 25,000 persons or less. While the per capita local expenditure requirements would generally increase in the proposed new section, the commission's review of currently-accredited libraries indicates that very few libraries would find it difficult to meet the proposed new minimums. The commission believes these minimum amounts are important because they offer communities statewide the means to set an operational framework that delivers a consistent, achievable, and meaningful base from which to provide essential core library services. The funding amounts are intended only to set a basic level of funding, with communities encouraged to fund their libraries to the capacity desired to achieve all local goals.

Proposed new §1.77, Other Operational Requirements, is a revision of previous §1.83, Other Requirements. The proposed revisions to the section primarily update and modernize the language. A proposed addition to previous §1.83(1) would add email address to the required contact information. Proposed §1.77(6) is a new requirement that would require a library to maintain policies addressing circulation, collection development, technology use, and information security and privacy and make those policies available to the public.

Proposed new §1.78, Annual Report, is a revision to previous §1.85, Annual Report. New §1.78 would state that to be eligible for accreditation, a public library must submit an annual report to the commission by the established deadline or the library will automatically lose accreditation for the upcoming state fiscal year and be ineligible for certain commission services and programs.

Proposed new §1.79, Emergency Waiver of Accreditation Criteria, is the same language previously found at §1.87, Emergency Waiver of Accreditation Criteria. No changes are proposed for this section.

Proposed new §1.80, Conditional Accreditation of Library, replaces previous §1.79, Provisional Accreditation of Library and previous §1.80, Probational Accreditation of Library. The proposed new section will establish one simple process for the granting of temporary accreditation when a library fails to meet one criterion in Subchapter C. The maximum length of time a library may be conditionally accredited is three years.

Proposed new §1.81, Loss of Accreditation, is a new section that outlines what might cause a library to lose accreditation, how the process will work, and what loss of accreditation means. If a library loses accreditation, it will not be accredited for the next state fiscal year and will not have access to certain commission services during that year. If the commission determines that a library does not meet the criteria for accreditation at any time during the accreditation year, the commission will notify the library in writing of the potential loss of accreditation. On notification of potential loss of accreditation, a library may be able come into compliance, choose to be unaccredited, or appeal the determination. The new section would also provide that if a library does not file its annual report by the established deadline, it will automatically lose accreditation for the upcoming state fiscal year. If a library is unaccredited for the year in question but wishes to be considered for accreditation in subsequent years, it must continue to submit an annual report. In all cases, a library must continue to submit an annual report to continue receiving certain minimum services.

Proposed new §1.82, Appeal of Accreditation Determination, is a new section that would establish the process for how a library may appeal the loss of accreditation. The library may first appeal to the Library Systems Act Advisory Board (LSA Board) and must include a formal letter of appeal to the director of the Library Development and Networking Division. The LSA Board will consider the matter at a meeting and make a recommendation on the appeal to the director and librarian, who will make a final determination. If the library does not agree with the director and librarian's determination, the library may appeal to the Commission following the requirements of §2.55, Protest Procedure.

FISCAL IMPACT. Sarah Karnes, Director, Library Development and Networking Division, has determined that for each of the first five years the proposed new sections are in effect, there are no reasonably foreseeable fiscal implications for the state or local governments as a result of enforcing or administering these rules, as proposed. Accreditation is not mandatory for a library to operate as a public library. Accreditation is an optional status that libraries may achieve if they wish to take advantage of certain agency programs and services. In addition, the commission has reviewed information from the most recently submitted annual reports and determined that most, if not all, currently-accredited libraries should be able to remain accredited based on the new sections, as proposed. In addition, libraries have almost two years to plan for the new requirements.

PUBLIC BENEFIT AND COSTS. Ms. Karnes has determined that for each of the first five years the proposed new sections are in effect, the anticipated public benefit will be the continued accreditation of public libraries based on criteria that update economic indicators, modernize technology requirements, and integrate provisions for enhanced public transparency, including delineating policies the library must maintain. Updating and improving the language of the rules will also ensure libraries better understand the accreditation process, leading to more libraries reporting and seeking accreditation. Members of the public would, therefore, benefit from increased access to additional services, programs, and opportunities provided by the library, such as internet access (available to accredited libraries at a discount through the federal E-Rate Program) and an enhanced collection (through the statewide interlibrary loan program).

There are no anticipated economic costs to persons required to comply with the proposed new sections, as accreditation is not required for public libraries.

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

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT STATEMENT. There will be no adverse economic effect on small businesses, micro-businesses, or rural communities; therefore, a regulatory flexibility analysis under Government Code, §2006.002 is not required.

COST INCREASE TO REGULATED PERSONS. The rules as proposed do not impose or increase a cost on regulated persons, including another state agency, a special district, or a local government. Therefore, the commission is not required to take any further action under Government Code, §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. In compliance with Government Code, §2001.0221, the commission provides the following government growth impact statement. For each year of the first five years the rules as proposed will be in effect, the commission has determined the following:

1. The rules as proposed will not create or eliminate a government program;

2. Implementation of the rules as proposed will not require the creation of new employee positions or the elimination of existing employee positions;

3. Implementation of the rules as proposed will not require an increase or decrease in future legislative appropriations to the commission;

4. The proposal will not require an increase or decrease in fees paid to the commission;

5. The proposal will create new regulations, but the commission is also proposing multiple sections for repeal in this same issue of the *Texas Register* resulting in fewer regulations in the subchapter overall;

6. The proposal will not expand, limit, or repeal an existing regulation;

7. The proposal will not increase the number of individuals subject to the proposed rules' applicability; and

8. The proposal will not positively or adversely affect the state's economy.

TAKINGS IMPACT ASSESSMENT. No private real property interests are affected by this proposal, and 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. Therefore, the proposed rules do not constitute a taking under Government Code, §2007.043.

REQUEST FOR PUBLIC COMMENT. Written comments on the proposed new sections may be submitted to Sarah Swanson, General Counsel, Texas State Library and Archives Commission, P.O. Box 12927, Austin, Texas, 78711, or via email at rules@tsl.texas.gov. To be considered, a written comment must be received no later than 45 days from the date of publication in the *Texas Register*.

STATUTORY AUTHORITY. The new sections are proposed under Government Code, §441.135, which authorizes the commission to adopt guidelines for the awarding of grants; §441.136, which authorizes the commission to adopt rules necessary to the administration of the program of state grants, including qualifications for major resource system membership; §441.127, which provides that to be eligible for membership in a major resource system or regional library system, a library must meet the accreditation standards established by the commission; and §441.122(1) and (2), which defines "accreditation of libraries" as the evaluation and rating of libraries according to commission accreditation standards and "accreditation standards" as the criteria established by the commission that a library must meet to be accredited and eligible for membership in a major resource system.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

§1.70. Purpose and Scope.

(a) Government Code, §441.006, charges the commission with adopting policies and rules to aid and encourage the development of and cooperation among all types of libraries. In addition, Government Code, Chapter 441, Subchapter I, authorizes the commission with setting accreditation standards for public libraries. Under this

authority, this subchapter prescribes the policies and standards for the accreditation of public libraries, which determines the eligibility of public libraries for state assistance through programs and services of the agency.

(b) Accreditation is not intended to evaluate the adequacy of a public library's staff, budget, resources, or services, nor is accreditation intended to limit or restrict the number of communities in Texas that wish to operate a public library. The accreditation process is designed to establish the minimum criteria a library must meet if the library wishes to take advantage of certain programs offered by the commission.

(c) The annual report described in §1.78 of this title (relating to Annual Report) is the mechanism by which accreditation criteria are reviewed and accreditation is awarded.

§1.71. Definitions.

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

(1) Accreditation--means the process by which a library is accredited by the Texas State Library and Archives Commission as having met the standards in this subchapter. Accreditation is not required but determines the eligibility of public libraries to receive state assistance through programs and services of the Texas State Library and Archives Commission.

(2) Agency--means the Texas State Library and Archives Commission as an agency of the state of Texas, including the staff, collections, archives, operations, programs, and property of the Texas State Library and Archives Commission.

(3) Commission--means the seven-member governing body of the Texas State Library and Archives Commission.

(4) Continuing education--means professional development activities for library directors that are instructional, free of lobbying, and relevant to the operation of a library. Activities may include workshops, appropriate conference sessions, online training, and courses.

(5) Library collection item--means any item in the library's catalog that may be circulated, including books, e-books, audio and e-audio books, video and e-video items, non-traditional educational items such as kits, instruments, and equipment, and locally licensed databases or other informational items as determined by professional library standards.

(6) Library operating hours--means the number of unique hours the library is open to the public as set by local governing authorities based on and subject to local considerations, including need and budget.

(7) Local fiscal year--means the 12-month period used by a local entity for budgeting and operations. For accreditation purposes, it is the fiscal year in which January 1 of the requested year falls.

(8) Per capita--means the locally funded operating expenditures of the library divided by the library's assigned population under §1.72 of this title (relating to Legal Service Area).

(9) Professional librarian--means a person holding a master's degree or comparable certification in library or information studies from an accredited program.

(10) Public library--means a library that is operated by a single public entity or board, that is freely open to all persons under identical conditions, that receives its financial support in whole or part from public funds, and that provides the following at a minimum:

(A) An organized collection of print or other library materials, or a combination thereof;

(B) Paid or contracted staff;

(C) An established schedule in which services of the staff are available to the public; and

(D) The facilities necessary to support such a collection, staff, and schedule.

(11) State fiscal year--means the 12-month period beginning September 1 and ending August 31.

§1.72. Legal Service Area.

(a) A public library's legal service area is based on the source(s) of local government funding for the library and the population assigned to the library as described below. Legal service area calculations will be determined as follows using the population in the most recent decennial census or official population estimate of the United States Department of Commerce, Bureau of the Census, if available:

(1) In counties with one or more public libraries that receive only city and private funds, each library is credited with serving the population of the city or cities from which it receives funds or with which it has a contract.

(2) In counties with only one public library and that library receives county funds, the library is credited with serving the entire county population.

(3) In counties with more than one public library that receives both city and county funds, the libraries that receive city and county funds are credited with serving their city population plus a percentage of the population living outside the cities. This percentage is the ratio of each city's population to the total of all the populations of cities with public libraries within the county.

(4) In counties with a library established by the county commissioners court and that receives no city funds or an incorporated library that receives no city funds, and one or more city libraries that receive county funds, the city libraries that receive county and city funds are credited with serving their city populations plus a percentage of the county population living outside the cities. The percentage is the ratio of each city's population to the county population. The county library or incorporated library that receives county funds and no city funds serves all county residents not served by a city library.

(5) In counties with one library that receives county funds and one or more public libraries that do not receive county funds, the library that receives county funds is credited with serving the county population less the populations of cities with public libraries.

(6) In counties with more than one library that receives county funds and no city funds, the county population living outside cities with public libraries will be prorated among the libraries in the same ratio as the county funds are allocated.

(7) When school districts contract with one or more nonprofit corporations, cities, municipalities, or counties for public library services as part of their students' educational program, the library is credited with serving the total population living within the school district, as published annually in the most recent Small Area Income and Poverty Estimate Program (SAIPE).

(8) Libraries that enter into agreements or contracts with counties, cities, municipalities, or school districts to provide public library services will be assigned the respective population under this section whether or not there is an exchange of funds.

(9) If a library believes it has been assigned an unrealistic population figure, it may request in writing that the Library Systems Act Advisory Board approve an exception to the population served methodology. The board will use its discretion to devise a method by which data from the United States Department of Commerce, Bureau of the Census will be used to calculate the legal service area.

(b) If a library does not report receiving public monies for public library service, that library will be assigned no population.

(c) Population estimates assigned at the beginning of the state fiscal year will remain in place throughout the following annual report submission and review process period until new populations are assigned for the following cycle. Any resulting population changes will go into effect with the next assignment of the legal service areas.

§1.73. Public Library Services.

(a) As provided in subsection (c) of this section, a public library must provide certain library services to the general public without charge regardless of the person's residency. As provided in subsection (d) of this section, a public library may charge for other services provided to any member of the public, regardless of the person's residency. As provided in subsection (e) of this section, a public library must provide other services to members of the public who reside in the library's legal service area without charge to those individuals but may charge nonresidents for those services.

(b) Library entities contracted with school districts to provide library services to the general public residing in the school district must provide services in addition to that provided to school students, faculty, and staff. Libraries must meet any policy requirements for K-12 school environments in addition to the public library requirements. Public library services must be provided at least the required number of hours all weeks of the year, except those weeks with national or state holidays.

(c) A public library must provide the following services to the general public without charge regardless of the person's residency:

(1) Dissemination of civic, community, or other ephemeral material freely available and not in the library's catalog;

(2) Circulation of materials to those with borrowing privileges;

(3) Reserving library materials to those with borrowing privileges;

(4) Reference services;

(5) Use of computers and other technology to access information sources, databases , or other similar services as allowed by local license agreements;

(6) Admission to the facility; and

(7) Admission to programs conducted by the library that are sponsored in whole or part by state resources.

(d) A public library may charge any member of the public for the following services at the discretion of the library's governing authority, regardless of the person's residency:

(1) Replacement of lost borrower cards;

(2) Fines for overdue, lost, or damaged materials in accordance with local library policies;

(3) Postage related to interlibrary loan;

(4) In-depth reference services provided on a contractual basis;

(5) Photocopying, scanning, printing, and fax services;

(6) Passport services;

(7) Library parking;

(8) Sale of publications and retail merchandise; and

(9) Rental and deposits on equipment and meeting and event spaces.

(e) A public library may charge nonresidents for borrowing privileges, which may include reserving materials and access to library programming.

(f) A public library shall serve all members of the general public, certifying annually that no person shall be excluded from participation in or denied the benefits of the appropriate services of that library in accordance with federal and state law.

§1.74. Public Library: Legal Establishment.

A public library must be established to provide general library services as provided in this section. To meet this requirement, a library must be established as:

(1) a department of a city, municipality, or county government by charter, resolution, or ordinance; or by contract as provided for in the Government Code, Chapter 791;

(2) a library district established under the provisions of Local Government Code, Chapter 326, Library Districts;

(3) a library district established under the provisions of Local Government Code, Chapter 336, Multi-Jurisdictional Library Districts; or

(4) a nonprofit corporation chartered by the Office of the Secretary of State for the purposes of providing free public library services for a city, municipality, county, and/or school district. A nonprofit public library must also have a contract with each governmental entity that provides funding to the library.

§1.75. Local Operating Expenditures.

(a) A public library must demonstrate local effort on an annual basis by maintaining or increasing local operating expenditures or per capita local operating expenditures. Expenditures for the current reporting year will be compared to the average of the total local operating expenditures or to the average of the total per capita local operating expenditures for the three preceding years.

(b) At least half of the annual local operating expenditures required to meet the minimum level of per capita support for accreditation must be from local government sources. Local government sources are defined as money appropriated by library districts, school districts, or city, municipal, or county governments.

(c) A public library must have minimum total local expenditures of $24,000 in local fiscal years 2026, 2027, 2028; at least $27,000 in local fiscal years 2029, 2030, 2031; at least $30,000 in local fiscal years 2032, 2033, 2034.

(d) A public library that expends at least $22.00 per capita is exempt from this accreditation criterion if it shows evidence of some library expenditures from local government sources and is open to the public under identical conditions without charge.

(e) A public library that expends at least $22.00 per capita and at least $200,000 of local funds is exempt from this accreditation criterion.

§1.76. Quantitative Standards for Accreditation of Library.

(a) A public library must meet the quantitative standards for accreditation in this section, in addition to the other requirements in this subchapter.

(b) A public library must have at least one library collection item per capita or expend at least 15% of the library's local expenditures on library collection items. If the library serves 25,000 persons or less, the library must maintain a collection of at least 7,500 library collection items.

(c) A public library must ensure at least 5% of its library collection items were published or created in the last five years.

(d) A public library must be open for service not less than 40 hours per week, except that a public library that serves 25,000 persons or less must be open for not less than 20 hours per week.

(e) A public library must employ a library director for at least 40 hours per week, except that a public library that serves 25,000 persons or less must employ a library director for at least 20 hours per week.

(f) A library director for a library serving a population of 100,001 or more must complete a minimum of 20 hours of continuing education annually. A library director for a library serving a population of 100,00 or less must complete a minimum of 10 hours of continuing education annually. A library director must maintain documentation of attendance, duration, and relevance of each continuing education credit claimed.

(g) A library must have local expenditures as follows:

(1) A library serving a population of 200,001 persons or more must have local expenditures equaling at least $13.50 per capita in local fiscal years 2026, 2027, 2028; at least $13.91 in local fiscal years 2029, 2030, 2031; and at least $14.32 per capita in local fiscal years 2032, 2033, 2034;

(2) A library serving a population of 100,001 - 200,000 persons must have local expenditures equaling at least $10.50 per capita in local fiscal years 2026, 2027, 2028; at least $10.82 in local fiscal years 2029, 2030, 2031; and at least $11.14 per capita in local fiscal years 2032, 2033, 2034;

(3) A library serving a population of 25,001 - 100,000 persons must have local expenditures equaling at least $7.50 per capita in local fiscal years 2026, 2027, 2028; at least $7.73 in local fiscal years 2029, 2030, 2031; and at least $7.96 per capita in local fiscal years 2032, 2033, 2034; and

(4) A library serving a population of 25,000 or less must have local expenditures equaling at least $5.50 per capita in local fiscal years 2026, 2027, 2028; at least $5.67 in local fiscal years 2029, 2030, 2031; and at least $5.83 per capita in local fiscal years 2032, 2033, 2034.

(h) A library must employ full-time equivalent professional librarians as follows:

(1) A library serving a population of 200,001 persons or more must employ at least six full-time equivalent professional librarians with one additional full-time equivalent professional librarian for every 50,000 persons above 200,000;

(2) A library serving a population of 100,001 - 200,000 persons must employ at least four full-time equivalent professional librarians, with one additional full-time equivalent professional librarian for every 50,000 persons above 100,000;

(3) A library serving a population of 25,001 - 100,000 persons must employ at least one full-time equivalent professional librarian, with one additional full-time equivalent professional librarian for every 50,000 persons above 50,000; and

(4) There is no additional staffing requirement for a library serving a population of 25,000 or less.

§1.77. Other Operational Requirements.

In addition to the quantitative standards in §1.76 (relating to Quantitative Standards for Accreditation of Library), each public library applying for accreditation must meet the following requirements and report to the agency on the status of each requirement annually:

(1) The library must have a website detailing current services and contact information, including a telephone number and email address.

(2) The library must have available technology to enable staff and the general public to access the Internet and print, copy, and scan materials.

(3) The library must have an integrated searchable catalog of its holdings available to the public online through the library's website.

(4) The library must offer to borrow materials through the statewide interlibrary loan system for eligible persons residing within the library's legal service area and offer to lend materials to other participating Texas libraries using the statewide interlibrary loan system. The library's governing board may adopt local policies regarding collections available to lend, lending periods and renewals, patron eligibility, and other factors. Local policies must be available to the public.

(5) The library must have a strategic plan that is approved by its governing authority and reviewed and updated at least every five years. The library's strategic plan may be part of a larger plan from the governing authority.

(6) At a minimum, the library must maintain current and publicly available policies or procedures, approved by the library's governing or designated authority, addressing the following subjects:

(A) Circulation;

(B) Collection Development;

(C) Technology Use; and

(D) Information Security and Privacy.

§1.78. Annual Report.

To be eligible for accreditation, a public library must submit a report each year detailing local library activity for the local fiscal year requested in a manner and form prescribed by the agency. A library that does not submit an annual report by the deadline established by the agency will automatically lose accreditation for the upcoming state fiscal year and be ineligible to access certain agency services and programs.

§1.79. Emergency Waiver of Accreditation Criteria.

One or more accreditation criteria in this subchapter may be waived if a library shows good cause for failure to meet the criteria. For purposes of this subchapter, good cause means a public health emergency, including, but not limited to, a pandemic or epidemic; a natural or man-made disaster, including, but not limited to, a tornado, hurricane, flood, wildfire, explosion, or chemical spill; or other extraordinary hardship which is beyond the control of the library as determined by the agency.

§1.80. Conditional Accreditation of Library.

(a) Conditional accreditation is a temporary status granted when a library fails to meet one criterion in this subchapter. A conditionally-accredited library enjoys the same benefits and privileges as

a fully accredited library. A library that fails to meet more than one criterion is not eligible for conditional accreditation.

(b) The maximum length of time a library may be conditionally accredited is three years. A library that is still unable to meet an accreditation criterion at the end of the conditional accreditation period, whether it is the same or a new criterion, will not be accredited and must reapply for accreditation the following year.

(c) A public library actively seeking accreditation by securing the per capita support necessary for qualification may be conditionally accredited on the basis of the library's current operating budget rather than its expenditures of the preceding year.

(d) To be fully accredited, a library must meet all accreditation requirements in this subchapter by the end of the conditional accreditation period.

§1.81. Loss of Accreditation.

(a) Accreditation is conditioned on submission of the annual report required in §1.78 of this title (relating to Annual Report) and meeting the accreditation criteria established by this subchapter. If a library loses accreditation, the library will not be accredited for the next fiscal year and will not have access to certain agency services during that year.

(b) If the agency determines a library does not meet the criteria for accreditation at any time during the accreditation year, the agency will notify the library in writing of the potential loss of accreditation.

(c) A public library that does not submit an annual report by the established deadline will automatically lose accreditation for the upcoming state fiscal year.

(d) A public library that does not meet the minimum criteria for accreditation required by this subchapter and as documented on the annual report may lose accreditation.

(e) On notification of the potential loss of accreditation, the agency may allow the library a reasonable period of time to come into compliance and remain accredited. A library may also choose to be unaccredited or appeal the determination.

(f) If a library chooses to be unaccredited for the year in question but wants to be considered for accreditation in subsequent years, the library must continue to submit an annual report each year it is not accredited. The library may be re-accredited during the next annual report cycle if the library reports data showing that it meets all accreditation criteria by the prescribed deadline. A library that lacks only one criterion for accreditation may be eligible for a waiver as detailed in §1.79 of this title (relating to Emergency Waiver of Accreditation Criteria).

(g) A library must continue to submit an annual report to continue to receive minimum agency services, such as the agency's summer reading program and access to consulting services.

§1.82. Appeal of Accreditation Determination.

(a) A library that is not accredited or that loses accreditation may appeal the determination to the Library Systems Act Advisory Board (LSA Board).

(b) To appeal a determination regarding accreditation, a library must notify the agency of its intention to appeal. On notification of the intent to appeal, the agency will provide the library with information on the process and documentation needed.

(c) A formal appeal must include a letter of appeal to the director of the Library Development and Networking division providing a detailed description of the accreditation issue and a proposed resolution and timeline. Appellants may include supporting documentation and letters of support with the letter of appeal.

(d) After considering the matter at its meeting, the LSA Board will make a recommendation on the appeal to the Director and Librarian of the Texas State Library and Archives Commission. The Director and Librarian will make a final determination based on the recommendation but is not bound by the LSA Board's recommendation.

(e) The agency will notify the library of the final determination, at which point, the library can accept the ruling or appeal to the commission following the agency's protest procedure as described in §2.55 of this title (relating to Protest Procedure).

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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TRD-202405311

Sarah Swanson

General Counsel

Texas State Library and Archives Commission

Earliest possible date of adoption: December 15, 2024

For further information, please call: (512) 463-5460

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TITLE 16. ECONOMIC REGULATION

PART 9. TEXAS LOTTERY COMMISSION

CHAPTER 402. CHARITABLE BINGO OPERATIONS DIVISION

The Texas Lottery Commission (Commission) proposes the repeal of existing 16 TAC §§402.301 (Bingo Card/Paper) and 402.303 (Pull-tab or Instant Bingo Dispensers); the addition of new 16 TAC §§402.105 (Postmarks, Timely Filing of Forms, Reports, Applications and Payment of Taxes and Fees), 402.301 (Approval of Pull-Tab Bingo Tickets), 402.302 (Pull-Tab Bingo Manufacturing Requirements), 402.303 (Pull-Tab Bingo Sales and Redemption), 402.304 (Pull-Tab Bingo Record Keeping), 402.305 (Pull-Tab Bingo Styles of Play), 402.306 (Bingo Card/Paper Definitions), 402.307 (Bingo Card/Paper Approval), 402.308 (Bingo Card/Paper Manufacturing Requirements), 402.309 (Bingo Card/Paper Record Keeping), 402.310 (Bingo Card/Paper Styles of Play), and 402.311 (Pull-Tab or Instant Bingo Dispensers); and amendments to 16 TAC §§402.100 (Definitions), 402.101 (Advisory Opinions), 402.102 (Bingo Advisory Committee), 402.103 (Training Program), 402.200 (General Restrictions on the Conduct of Bingo), 402.201 (Prohibited Bingo Occasion), 402.202 (Transfer of Funds), 402.203 (Unit Accounting), 402.210 (House Rules), 402.212 (Promotional Bingo), 402.300 (Pull-Tab Bingo), 402.324 (Card-Minding Systems--Approval of Card-Minding Systems), 402.325 (Card-Minding Systems--Licensed Authorized Organizations Requirements), 402.326 (Card-Minding Systems--Distributor Requirements), 402.334 (Shutter Card Bingo Systems - Approval of Shutter Card Bingo Systems), 402.400 (General

Licensing Provisions), 402.401 (Temporary License), 402.402 (Registry of Bingo Workers), 402.404 (License Classes and Fees), 402.411 (License Renewal), 402.443 (Transfer of a Grandfathered Lessor's Commercial Lessor License), 402.500 (General Records Requirements), 402.502 (Charitable Use of Net Proceeds Recordkeeping), 402.600 (Bingo Reports and Payments), 402.601 (Interest on Delinquent Tax), 402.602 (Waiver of Penalty, Settlement of Prize Fees, Penalty and/or Interest), 402.702 (Disqualifying Convictions), 402.703 (Audit Policy), 402.706 (Schedule of Sanctions), and 402.707 (Expedited Administrative Penalty Guideline).

The proposed repeals, new rules, and amendments are the result of the Commission's recent rule review conducted in accordance with Texas Government Code §2001.039, as well as the agency's recent review by the Texas Sunset Advisory Commission. Among the more significant changes, this proposal addresses issues identified as rulemaking gaps in the May 2024 Texas Sunset Advisory Commission Staff Report (Staff Report). Specifically, the Staff Report noted that there was "no clarification of what classifies as a bingo hall's "premises..." (addressed in Rule 402.100), "no clarification that bingo products may not be purchased using a credit card ..." (addressed in Rule 402.200), "no clarification of how certain grandfathered bingo licenses may be transferred" (addressed in Rule 402.443), and "no definition of what constitutes a repeat violation ..." (addressed in Rule 402.706). The Staff Report also recommended considering a licensee's compliance history in audit determinations (addressed in Rule 402.703) and eliminating warnings for serious offenses and repeat violations of less serious offenses (addressed in Rules 402.706 and 402.707).

This proposal also amends aspects of the Bingo Advisory Committee (BAC) to ensure that it complies with the Bingo Enabling Act (BEA); breaks two comprehensive rules on pull-tabs and bingo paper into multiple smaller rules for ease of reference; creates a single standard for determining when a form, report, application, or payment has been mailed to the Commission; clarifies and updates agency processes; eliminates references to terms, laws, and processes that are no longer in place; and conforms the rules to the BEA.

The proposed new Rule 402.105 establishes a single standard for determining the timeliness of filings by licensees. A form, report, application, or payment will be deemed filed or paid based on the postmark or receipt mark date, or, if filed electronically, the day that it was filed. Currently, there are different standards throughout the rules depending on the type of document or payment filed. The different standards will be deleted in this rulemaking and replaced by this single rule. This new rule was modeled on a similar rule adopted by the Comptroller of Public Accounts used to determine the timeliness of tax payments and related forms.

The proposed new Rules 402.301, 402.302, 402.303, 402.304 and 402.305 are necessary to break the current Rule 402.300, regarding pull-tab bingo tickets, into smaller rules for ease of reference. There are no changes to the rule language from the current version.

The proposed new Rules 402.306, 402.307, 402.308, 402.309, and 402.310 are necessary to break the current Rule 402.301, regarding bingo card/paper, into smaller rules for ease of reference. The new Rules 402.306 and 402.310 also contain amendments allowing break-open bingo games to be pre-called, and will properly categorize braille and loteria cards as bingo equipment that require approval by the Commission. There are no other changes to the rule language from the current version.

The proposed new Rule 402.311, regarding pull-tab or instant bingo dispensers, is currently at Rule 402.303 and needs to be moved to break Rule 402.300 into multiple parts. There are no changes to the rule language from the current version.

The proposed amendments to Rule 402.100 include a definition of "premises" that conforms with the BEA. This change addresses a gap that was identified by the Staff Report.

The proposed amendments to Rule 402.101 change a reference to the bingo operations director from "his" to "his or her" and eliminate the requirement that the general counsel approve a bingo advisory opinion before it is issued.

The proposed amendments to Rule 402.102 eliminate the appointment of a substitute member to the BAC if a member from one of the required interest groups cannot be appointed; clarify that a member serves at the pleasure of the Commission or until they resign or are unable to serve; provide for virtual meetings; and clarify the BAC's annual reporting deadline and reappointment process.

The proposed amendments to Rule 402.103 clarify that conductors may only choose an on-site bingo training program if one is available. The amendments also codify the agency's practice that non-regular conductors are not subject to training requirements.

The proposed amendments to Rule 402.200 correct a typo and specify that formal complaints to the Commission must be in writing. The amendments also codify a prior bingo advisory opinion that organizations may not accept credit payments for bingo products. This change addresses a gap that was identified by the Staff Report.

The proposed amendments to Rule 402.201 codify the longstanding Commission practice and process of issuing cease-and-desist letters and copying local law enforcement in substantiated cases of illegal bingo.

The proposed amendments to Rule 402.202 delete a reference to the timely submission of a transfer of funds form. This rule is no longer necessary due to the new rule on timeliness of submissions at Rule 402.105.

The proposed amendments to Rule 402.203 delete a reference that allows the sale of pull-tab bingo tickets between organizations with the prior written consent of the Commission. The authority for an organization to sell certain bingo products to another organization with the prior approval of the Commission comes from Bingo Enabling Act §2001.407(f). That section does not provide for the sale of pull-tabs.

The proposed amendments to Rule 402.210 require organizations to prohibit any person from offering to sell bingo products or offering to award bingo prizes to persons outside of a bingo occasion via a telecommunications device.

The proposed amendments to Rule 402.212 clarify that approval for a promotional bingo event will only be issued if the request complies with all the requirements of the rule.

The proposed amendments to Rule 402.300 are necessary to break the current Rule 402.300, regarding pull-tab bingo tickets, into smaller rules for ease of reference. There are no changes to the rule language from the current version.

The proposed amendments to Rule 402.324 eliminate all references to the Commission's testing lab and require manufacturers to provide any forms and documentation necessary to ensure that their card-minding systems comply with required standards.

The proposed amendments to Rule 402.325 provide that the voided receipts organizations are required to attach to the bingo occasion report must include all payments (cash or otherwise) for pre-sales.

The proposed amendments to Rule 402.326 delete an obsolete reference to "dedicated modem phone lines."

The proposed amendments to Rule 402.334 provide that a manufacturer must provide any software necessary to determine if its shutter card bingo system meets rule requirements.

The proposed amendments to Rule 402.400 provide that the Commission will not return a license application when the applicant has failed to respond to a request for more information within 21 days.

The proposed amendments to Rule 402.401 clarify that a regular organization that surrenders its regular license may retain up to 12 unused temporary licenses so long as their dates-of-use are designated within 10 days of the surrender. The amendments also correct references to two forms.

The proposed amendments to Rule 402.402 eliminate the requirement for an applicant to list his or her race on an application for the worker registry.

The proposed amendments to Rule 402.404 eliminate unnecessary references to "regular" licenses.

The proposed amendments to Rule 402.411 allow the division to "provide" renewal notices rather than "mail" them, and delete a reference to the timely submission of license renewal applications, which is no longer necessary due to the proposed new Rule 402.105.

The proposed amendments to Rule 402.443 provide that a grandfathered license held by a legal entity is not considered to be transferred due to changes to the legal entity so long as the entity's taxpayer number remains the same. This rule codifies the Commission's practice on the transfer of grandfathered lessor licenses and conforms with a previously issued Office of the Attorney General Opinion. This change addresses a gap that was identified by the Staff Report.

The proposed amendments to Rule 402.500 codify the Commission's practice that bingo operations must use cash basis accounting.

The proposed amendments to Rule 402.502 eliminate unnecessary language related to the kinds of documentation that may be relied on to prove charitable distributions were properly made.

The proposed amendments to Rule 402.600 delete references to the timely submission of bingo reports and payments. These references are no longer necessary due to the new rule on timeliness of all submissions at Rule 402.105.

The proposed amendments to Rule 402.601 provide that a credit of $100 or less entered by an organization or lessor on its quarterly report will be accessible for viewing in the Bingo Service Portal, rather than preprinted on the quarterly report.

The proposed amendments to Rule 402.602 eliminate waivers of penalties and interest due to the late payment of prize fees. Penalties and interest for late prize fee payments come from BEA §2001.504. That section does not provide for a waiver of the penalty and interest, in contrast to BEA §2001.451(k) which explicitly allows the director to waive net proceeds and charitable distribution requirements. The difference between those provisions indicates that the legislature did not intend to give the director the ability to waive penalties and interest for the late payment of prize fees.

The proposed amendments to Rule 402.702 eliminate a reference to a statute that no longer exists.

The proposed amendments to Rule 402.703 provide that a licensee's compliance history shall be considered as a risk factor in audit determinations. This change addresses a gap that was identified by the Staff Report.

The proposed amendments to Rule 402.706 eliminate warnings for first time violations of serious offenses or repeat violations of lesser offenses. The amendments also provide a definition of "repeat violation." This change addresses a gap that was identified by the Staff Report.

The proposed amendments to Rule 402.707 change the bingo operations director's pronoun from "his" to "his or her"; reiterate that formal complaints must be in writing; and eliminate warnings for repeat offenses. This change addresses a gap that was identified by the Staff Report.

LaDonna CastaÃ±uela, Charitable Bingo Operations Director, has determined that for each year of the first five years the proposed repeals, new rules and amendments will be in effect, the public benefit expected includes clearer and more efficient standards on filing deadlines and other division processes; more easily searchable rules; correction of typos and deletion of obsolete rules; conforming the rules to the Bingo Enabling Act with respect to the Bingo Advisory Committee, penalty waivers, and the transfer of pull-tabs; and addressing issues identified as rulemaking gaps in the Staff Report.

Sergio Rey, Controller, has determined that for each year of the first five years the proposed repeals, new rules and amendments will be in effect, there will be no significant fiscal impact for state or local governments as a result of the proposed repeals, new rules and amendments. There will be no adverse effect on small businesses or rural communities, micro businesses, or local or state employment. There will be no additional economic cost to persons required to comply with the repeals, new rules and amendments, as proposed. Furthermore, an Economic Impact Statement and Regulatory Flexibility Analysis is not required because the proposed repeals, new rules and amendments will not have an adverse economic effect on small businesses or rural communities as defined in Texas Government Code §2006.001(1-a) and (2).

Pursuant to Texas Government Code §2001.0221, the Commission provides the following Government Growth Impact Statement for the proposed repeals, new rules and amendments. For each year of the first five years the proposed repeals, new rules and amendments will be in effect, Sergio Rey, Controller, has determined the following:

(1) The proposed repeals, new rules and amendments do not create or eliminate a government program.

(2) Implementation of the proposed repeals, new rules and amendments does not require the creation of new employee positions or the elimination of existing employee positions.

(3) Implementation of the proposed repeals, new rules and amendments does not require an increase or decrease in future legislative appropriations to the Commission.

(4) The proposed repeals, new rules and amendments do not require an increase or decrease in fees paid to the Commission.

(5) The proposed repeals, new rules and amendments do not create a new regulation.

(6) The proposed repeals, new rules and amendments do not expand or limit an existing regulation.

(7) The proposed repeals, new rules and amendments do not increase or decrease the number of individuals subject to the rule's applicability.

(8) The proposed repeals, new rules and amendments do not positively or adversely affect this state's economy.

The Commission requests comments on the proposed repeals, new rules and amendments from any interested person. Comments may be submitted to Tyler Vance, Assistant General Counsel, by mail at Texas Lottery Commission, P.O. Box 16630, Austin, Texas 78761-6630; by facsimile at (512) 344-5189; or by email at *legal.input@lottery.state.tx.us*. Comments must be received within 30 days after publication of this proposal in the *Texas Register* to be considered. The Commission will also hold a public hearing to receive comments on this proposal at 1:00 p.m. on December 4, 2024, at 1801 Congress Ave., George H. W. Bush Building, 4th Floor, Board Room 4.300, Austin, TX, 78701.

SUBCHAPTER A. ADMINISTRATION

16 TAC §§402.100 - 402.103

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.100. Definitions.

The following words and terms, when used in this chapter and Texas Occupations Code, Chapter 2001, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (8) (No change.)

(9) Premises--The area subject to the direct control of and actual use by a licensed authorized organization or group of authorized organizations to conduct bingo. There may not be more than one premises under a common roof or over a common foundation. A premises must have an address. The term does not include a virtual location or place.

§402.101. Advisory Opinions.

(a) Time Period.

(1) - (2) (No change.)

(3) The authority granted by Occupations Code, §2001.059, is delegated to the Charitable Bingo Operations Director or his or her designee. [~~The General Counsel must approve the advisory opinion prior to the issuance of the advisory opinion by the Charitable Bingo Operations Director.~~] The Commission by separate order may delegate to an employee of the Commission the authority granted.

(4) (No change.)

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

§402.102. Bingo Advisory Committee.

(a) (No change.)

(b) What is the composition of the Bingo Advisory Committee?

(1) - (2) (No change.)

[~~(3) If there is not an individual to represent one of the required interest groups, the Commission may appoint a member from the remaining interest groups.~~]

(c) - (e) (No change.)

(f) [~~How long may members serve on the BAC?~~]

[~~(1) The Commission appoints each member to serve for a one-year term or until the Commission appoints a successor.~~]

[~~(2)~~] Each member serves at the pleasure of the Commission or until they resign or are unable to serve.

(g) (No change.)

(h) When and where does the BAC meet?

(1) (No change.)

(2) BAC meetings may [~~must~~] be held virtually or at a state office building [~~the Commission headquarters~~] in Austin, Texas. [~~Texas; provided that, meetings may be held at a location in Texas other than Austin, subject to the discretion of the Commission and BAC presiding officer.~~]

(i) - (m) (No change.)

(n) What are the BAC's reporting requirements?

(1) - (2) (No change.)

(3) At the final Commission meeting of any state fiscal year, the BAC will report to the Commission on its activities relating to the Commission-approved workplan for the preceding fiscal year [~~At the first Commission meeting held prior to September 1 each year, the BAC will provide to the Commission a report of its activities as they relate to the workplan approved by the Commission the previous year~~].

(o) When does the BAC cease to exist? The BAC will cease to exist annually on August 31, unless the Commission, prior to August 31, votes to continue the BAC. The Commission may continue the BAC with the current members in place.

§402.103. Training Program.

(a) (No change.)

(b) Training format. The training program is offered online and may be offered on-site [~~in two formats-on-site and on-line. Individuals may choose an on-site or on-line training course~~].

(c) Required training.

(1) - (4) (No change.)

(5) Non-regular conductors are not subject to training requirements.

(d) - (g) (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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Bob Biard
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16 TAC §402.105

The new rule is proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.105. Postmarks, Receipt Marks, Timely Filing of Forms, Reports, Applications and Payment of Fees.

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

(1) Common carrier--A person who provides transportation of persons or property to members of the general public for compensation in the normal course of business.

(2) Receipt mark--An official mark printed by a common carrier recording the date and place of mailing.

(3) United States Postal Service postmark--An official mark printed over a postage stamp by the United States Postal Service, canceling the stamp and recording the date and place of mailing. A postmark does not include dates recorded on postage purchased over the internet, pre-metered stamps, or postage from postage meters unless an actual postmark is generated.

(b) General Provisions.

(1) All forms, reports, and applications required to be submitted to the commission shall be filed on or before the due date for filing the form, report, or application.

(2) All payments required to be remitted to the commission shall be paid on or before the due date for making such payments.

(3) If the due date falls on a Saturday, Sunday, or legal holiday, the due date is the next business day.

(4) If a form, report, application, or payment is postmarked or receipt-marked on or before the due date, it will be considered timely filed.

(c) Timely Filing or Payment - Postmark or Receipt Mark.

(1) To determine whether a form, report, or application has been timely filed, or a payment timely made, the date of the United States Postal Service postmark or a receipt mark showing when a report or payment was delivered to a common carrier will be prima facie evidence of the date the filing or payment was made, so long as the envelope, or common carrier or contract carrier documentation, reflects a valid commission address.

(2) If a report or payment is received through the United States Postal Service and does not have a postmark, or is received through a common carrier and does not have a receipt mark, the date of the filing or payment is presumed, in the absence of evidence supporting the assertion of a different filing date, to be:

(A) if received through the United States Postal Service, three days prior to the date on which the form, report, application, or payment is physically received by the commission, as evidenced by commission records; or

(B) if received through a common carrier, one day prior to the date on which the report or payment is physically received by the commission, as evidence by commission records.

(3) If a licensee penalized for late filing or late payment can provide a postmark or receipt mark complying with the requirements of timely filing and timely paying but, through no fault of the licensee, the form, report, application, or payment arrived after the due date, the filing or payment will be considered timely. The licensee's testimony that the form, report, application, or payment was sent will not be considered as evidence of timely filing or payment.

(4) A form, report, application, or payment that is submitted electronically will be considered filed or paid on the date it is received.

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 B. CONDUCT OF BINGO

16 TAC §§402.200 - 402.203, 402.210, 402.212

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.200. General Restrictions on the Conduct of Bingo.

(a) - (h) (No change.)

(i) The licensed authorized organization is responsible for ensuring the following minimum requirements are met to conduct a bingo occasion in a manner that is fair.

(1) (No change.)

(2) Each licensed authorized organization shall conspicuously display during all bingo occasions a sign indicating the name(s) of the operator(s) authorized by the licensed authorized organization to be in charge of the occasion.

(A) - (B) (No change.)

(C) The sign should further state that if the player is not satisfied with the response given by the operator that the player has the right to contact the Commission and file a formal written complaint.

(3) - (4) (No change.)

(j) - (l) (No change.)

(m) Verification.

(1) Winning cards. The numbers appearing on the winning card must be verified at the time the winner is determined and prior to prize(s) being awarded in order to ensure [~~insure~~] that the numbers on the card in fact have been drawn from the receptacle.

(A) - (B) (No change.)

(2) (No change.)

(n) - (p) (No change.)

(q) A licensed authorized organization may not accept credit cards or any other type of credit payments for the payment of bingo products, regardless of how the transaction is structured.

§402.201. Prohibited Bingo Occasions.

(a) No licensee shall sell bingo cards for a bingo occasion or commence or continue a bingo occasion unless an active member that has been designated pursuant to the Occupations Code, §2001.411, is physically present at the bingo premises and is actively supervising and directing the sale of bingo cards and the bingo occasion. Any sale of bingo cards, game of bingo, or bingo occasion conducted in violation of this provision is a violation of the Bingo Enabling Act.

(b) If a complaint regarding illegal bingo is substantiated, the Commission will issue a cease and desist letter and copy local law enforcement if the location is known.

§402.202. Transfer of Funds.

(a) (No change.)

(b) Notification of the transfer of funds into the bingo account or bingo unit account must be submitted on a form prescribed by the Commission. [~~To be timely submitted, the notification's postmark date, date of delivery for common carrier, date of e-mail, or date of facsimile must clearly show a date that is no later than 14 calendar days after the date the funds were transferred.~~]

(c) - (i) (No change.)

§402.203. Unit Accounting.

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

(g) Unit Transactions.

(1) Upon prior written consent by the Commission:

(A) a licensed authorized organization may make a sale of bingo cards, [~~pull-tab bingo tickets, or~~] a used bingo flash board or blower to a unit;

(B) a unit may make a sale of bingo cards, [~~pull-tab bingo tickets, or~~] a used bingo flash board or blower to a licensed authorized organization; or

(C) a unit may make a sale of bingo cards, [~~pull-tab bingo tickets, or~~] a used bingo flash board or blower to another unit.

(2) [~~(D)~~] Within thirty (30) calendar days of initially joining a unit, the licensed authorized organization shall notify the Commission of the bingo cards and pull-tab bingo tickets transferred to the unit.

(3) [~~(2)~~] If a member of a unit is in default, a person may not sell or transfer bingo equipment or supplies to the unit on terms other than immediate payment on delivery.

(h) - (l) (No change.)

§402.210. House Rules.

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

(g) House rules shall prohibit any person from offering to sell bingo products, or offering to award bingo prizes to persons outside of the licensed location during an occasion via cell phone, laptop computer, electronic tablet, or other telecommunications device.

§402.212. Promotional Bingo.

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

(c) Notification.

(1) (No change.)

(2) The commission will issue a Recognition of Exemption Notice for Promotional Bingo Games letter to the business filing a notice that complies with the requirements of this section [~~the prescribed form to conduct the exempt promotional bingo game~~].

(d) (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 C. BINGO GAMES AND EQUIPMENT

16 TAC §§402.300, 402.324 - 402.326, 402.334

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.300. Pull-Tab Bingo Definitions.

[~~(a)~~] Definitions. The following words and terms, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Bingo Ball Draw--A pulling of a bingo ball(s) to determine the winner of an event ticket by either the number or color on the ball(s).

(2) Deal--A separate and specific game of pull-tab bingo tickets of the same serial number and form number.

(3) Face--The side of a pull-tab bingo ticket, which displays the artwork of a specific game.

(4) Flare--A poster or placard that must display:

(A) a form number of a specific pull-tab bingo game;

(B) the name of the pull-tab bingo game;

(C) the total card count of the pull-tab bingo game;

(D) the cost per pull-tab bingo ticket;

(E) the number of prizes to be awarded and the corresponding prize amounts of the pull-tab bingo game; and

(F) the name of the manufacturer or trademark.

(5) Form Number--The unique identification number assigned by the manufacturer to a specific pull-tab bingo game. A form number may be numeric, alpha, or a combination of numeric and alpha characters.

(6) High Tier--The two highest paying prize amounts as designated on the pull-tab bingo ticket and on the game's flare.

(7) Last Sale--The purchaser of the last pull-tab bingo ticket(s) sold in a deal with this feature is awarded a prize or a registration for the opportunity to win a prize.

(8) Merchandise--Any non-cash item(s), including bingo equipment, provided to a licensed authorized organization that is used as a prize.

(9) Pay-Out--The total sum of all possible prize amounts in a pull-tab bingo game.

(10) Payout Schedule--A printed schedule prepared by the manufacturer that displays:

(A) the name of the pull-tab bingo game;

(B) the form number of the pull-tab bingo game;

(C) the total card count of the pull-tab bingo game;

(D) the cost per pull-tab bingo ticket;

(E) the number of prizes to be awarded and the corresponding prize amount or jackpot for each category of the pull-tab bingo game;

(F) the number of winners for each category of prize;

(G) the profit of the pull-tab bingo game;

(H) the percentage of payout or the percentage of profit of the pull-tab bingo game; and

(I) the payout(s) of the pull-tab bingo game.

(11) Payout Structure--The printed information that appears on a pull-tab bingo ticket that shows the winnable prize amounts, the winning patterns required to win a prize, and the number of winners for each category of prize.

(12) Prize--An award of collectible items, merchandise, cash, bonus pull-tabs, and additional pull-tab bingo tickets, individually or in any combination.

(13) Prize Amount--The value of cash and/or merchandise which is awarded as a prize, as valued under §402.200(f) of this chapter. A collectable item is considered merchandise for determining allowable prize amounts.

(14) Serial Number--The unique identification number assigned by the manufacturer identifying a specific deal of pull-tab bingo tickets. A serial number may be numeric, alpha, or a combination of numeric and alpha characters.

(15) Subset--A part of a deal that is played as a game to itself or combined with more subsets and played as a game. Each subset may be designed to have:

(A) a designated payout; or

(B) a series of designated payouts. Subsets must be of the same form and serial number to have a combined designated payout or a series of designated payouts.

(16) Symbol--A graphic representation of an object other than a numeric or alpha character.

(17) Video Confirmation--A graphic and dynamic representation of the outcome of a bingo event ticket that will have no effect on the result of the winning or losing event ticket.

(18) Wheels--Devices that determine event ticket winner(s) by a spin of a wheel.

(19) Consecutive bingo occasions within one day--More than one bingo occasion conducted by an organization or organizations in the same unit within a 24-hour period without any intervening occasions conducted by another organization or organization from a different unit, commencing at the start of the first occasion.

[~~(b) Approval of pull-tab bingo tickets.~~]

[~~(1) A pull-tab bingo ticket may not be sold in the state of Texas, nor furnished to any person in this state nor used for play in this state until that pull-tab bingo ticket has received approval for use within the state of Texas by the Commission. The manufacturer at its own expense must present their pull-tab bingo ticket to the Commission for approval.~~]

[~~(2) All pull-tab bingo ticket color artwork with a letter of introduction including style of play must be presented to the Commission's Austin, Texas location for review. The manufacturer must submit one complete color positive or hardcopy set of the color artwork for each pull-tab bingo ticket and its accompanying flare. The color artwork may be submitted in an electronic format prescribed by the Commission in lieu of the hardcopy submission. The submission must include the payout schedule. The submission must show both sides of a pull-tab bingo ticket and must be submitted on an 8 1/2" x 11" size sheet. The color artwork will show the actual size of the ticket and a 200% size of the ticket. The color artwork will clearly identify all winning and non-winning symbols. The color artwork will clearly identify the winnable patterns and combinations.~~]

[~~(3) The color artwork for each individual pull-tab bingo ticket must:~~]

[~~(A) display in no less than 26-point diameter circle, an impression of the Commission's seal with the words "Texas Lottery Commission" engraved around the margin and a five-pointed star in the center;~~]

[~~(B) contain the name of the game in a conspicuous location on the pull-tab bingo ticket;~~]

[~~(C) contain the form number assigned by the manufacturer in a conspicuous location on the pull-tab bingo ticket;~~]

[~~(D) contain the manufacturer's name or trademark in a conspicuous location on the pull-tab bingo ticket;~~]

[~~(E) disclose the prize amount and number of winners for each prize amount, the number of individual pull-tab bingo tickets contained in the deal, and the cost per pull-tab bingo ticket in a conspicuous location on the pull-tab bingo ticket;~~]

[(F) display the serial number where it will be printed in a conspicuous location on the pull-tab bingo ticket. The color artwork may display the word "sample" or number "000000" in lieu of the serial number;]

[(G) contain graphic symbols that preserve the integrity of the Commission. The Commission will not approve any pull-tab bingo ticket that displays images or text that could be interpreted as depicting violent acts, profane language, or provocative, explicit, or derogatory images or text, as determined by the Commission. All images or text are subject to final approval by the Commission; and]

[(H) be accompanied with the color artwork of the pull-tab bingo tickets along with a list of all other colors that will be printed with the game.]

[(4) Upon approval of the color artwork, the manufacturer may be notified by the Commission to submit a specified number of tickets for testing. The tickets must be submitted for testing to the Commission at the manufacturer's own expense. If necessary, the Commission may request that additional tickets or a deal be submitted for testing.]

[(5) If the color artwork is approved and the pull-tab bingo tickets pass the Commission's testing, the manufacturer will be notified of the approval. This approval only extends to the specific pull-tab bingo game and the specific form number cited in the Commission's approval letter. If the pull-tab bingo ticket is modified in any way, with the exception of the serial number, index color, or trademark(s), it must be resubmitted to the Commission for approval. Changes to symbols require only an artwork approval from the Commission.]

[(6) The Commission may require resubmission of an approved pull-tab bingo ticket at any time.]

[(c) Disapproval of pull-tab bingo tickets.]

[(1) Upon inspection of a pull-tab bingo ticket by the Commission, if it is deemed not to properly preserve the integrity or security of the Commission including compliance with the art work requirements of this rule, the Commission may disapprove a pull-tab bingo ticket. All pull-tab bingo tickets that are disapproved by the Commission will cease to be allowed for sale until such time as the manufacturer complies with the written instructions of the Commission, or until any discrepancies are resolved. Disapproval of and prohibition to use, purchase, sell or otherwise distribute such a pull-tab bingo ticket is effective immediately upon notice to the manufacturer by the Commission. Upon receipt of such notice, the manufacturer must immediately notify the distributor and the distributor must immediately notify affected licensed authorized organizations to cease all use, purchase, sale or other distribution of the disapproved pull-tab ticket. The distributor must provide to the Commission, within 15 days of the Commission's notice to the manufacturer, confirmation that the distributor has notified the licensed authorized organization that the pull-tab ticket has been disapproved and sale and use of the disapproved ticket must cease immediately.]

[(2) If modified by the manufacturer all disapproved pull-tab bingo tickets may be resubmitted to the Commission. No sale of disapproved tickets will be allowed until the resubmitted tickets have passed security testing by the Commission. At any time the manufacturer may withdraw any disapproved pull-tab bingo tickets from further consideration.]

[(3) The Commission may disapprove a pull-tab bingo game at any stage of review, which includes artwork review and security testing, or at any time in the duration of a pull-tab bingo game. The disapproval of a pull-tab bingo ticket is administratively final.]

[(d) Manufacturing requirements.]

[(1) Manufacturers of pull-tab bingo tickets must manufacture, assemble, and package each deal in such a manner that none of the winning pull-tab bingo tickets, nor the location, or approximate location of any winning pull-tab bingo ticket can be determined in advance of opening the deal by any means or device. Nor should the winning pull-tab bingo tickets, or the location or approximate location of any winning pull-tab bingo ticket be determined in advance of opening the deal by manufacture, printing, color variations, assembly, packaging markings, or by use of a light. Each manufacturer is subject to inspection by the Commission, its authorized representative, or designee.]

[(2) All winning pull-tab bingo tickets as identified on the payout schedule must be randomly distributed and mixed among all other pull-tab bingo tickets of the same serial number in a deal regardless of the number of packages, boxes, or other containers in which the deal is packaged. The position of any winning pull-tab bingo ticket of the same serial numbers must not demonstrate a pattern within the deal or within a portion of the deal. If a deal of pull-tabs is packed in more than one box or container, no individual container may indicate that it includes a winner or contains a disproportionate share of winning or losing tickets.]

[(3) Each deal's package, box, or other container shall be sealed at the manufacturer's factory with a seal including a warning to the purchaser that the deal may have been tampered with if the package, box, or other container was received by the purchaser with the seal broken.]

[(4) Each deal's serial number shall be clearly and legibly placed on the outside of the deal's package, box or other container or be able to be viewed from the outside of the package, box or container.]

[(5) A flare must accompany each deal.]

[(6) The information contained in subsection (a)(3)(A), (B), (C), (D), and (F) of this section shall be located on the outside of each deal's sealed package, box, or other container.]

[(7) Manufacturers must seal or tape, with tamper resistant seal or tape, every entry point into a package, box or container of pull-tab bingo tickets prior to shipment. The seal or tape must be of such construction as to guarantee that should the container be opened or tampered with, such tampering or opening would be easily discernible.]

[(8) All high tier winning instant pull-tab bingo tickets must utilize a secondary form of winner verification.]

[(9) Each individual pull-tab bingo ticket must be constructed so that, until opened by a player, it is substantially impossible, in the opinion of the Commission, to determine its concealed letter(s), number(s) or symbol(s).]

[(10) No manufacturer may sell or otherwise provide to a distributor and no distributor may sell or otherwise provide to a licensed authorized organization of this state or for use in this state any pull-tab bingo game that does not contain a minimum prize payout of 65% of total receipts if completely sold out.]

[(11) A manufacturer in selling or providing pull-tab bingo tickets to a distributor shall seal or shrink-wrap each package, box, or container of a deal completely in a clear wrapping material.]

[(12) Pull-tab bingo tickets must:]

[(A) be constructed of cardboard and glued or otherwise securely sealed along all four edges of the pull-tab bingo ticket and between the individual perforated break-open tab(s) on the ticket. The glue must be of sufficient strength and type so as to prevent the separation of the sides of a pull-tab bingo ticket;]

[(B) have letters, numbers or symbols that are concealed behind perforated window tab(s), and allow such letters, numbers or symbols to be revealed only after the player has physically removed the perforated window tab(s);]

[(C) prevent the determination of a winning or losing pull-tab bingo ticket by any means other than the physical removal of the perforated window tab(s) by the player;]

[(D) be designed so that the numbers and symbols are a minimum of 2/32 (4/64) inch from the dye-cut window perforations;]

[(E) be designed so that the lines or arrows that identify the winning symbol combinations will be a minimum of 5/32 inch from the open edge farthest from the hinge of the dye-cut window perforations;]

[(F) be designed so that highlighted "pay-code" designations that identify the winning symbol combinations will be a minimum of 3.5/32 (7/64) inch from the dye-cut window perforations;]

[(G) be designed so that secondary winner protection codes appear in the left margin of the ticket,]unless the secondary winner protection codes are randomly generated serial number-type winner protection codes. Randomly generated serial number-type winner protection codes will be randomly located in either the left or middle column of symbols and will be designed so that the numbers are a minimum of 3.5/32 (7/64) inch from the dye-cut window perforations. Any colored line or bar or background used to highlight the winner protection code will be a minimum 3.5/32 (7/64) inch from the dye-cut window perforations;]

[(H) have the Commission's seal placed on all pull-tab bingo tickets by only a licensed manufacturer; and]

[(I) be designed so that the name of the manufacturer or its distinctive logo, form number and serial number unique to the deal, name of the game, price of the ticket, and the payout structure remain when the letters, numbers, and symbols are revealed.]

[(13) Wheels must be submitted to the Commission for approval. As a part of the approval process, the following requirements must be demonstrated to the satisfaction of the Commission:]

[(A) wheels must be able to spin at least four times with reasonable effort;]

[(B) wheels must only contain the same number or symbols as represented on the event ticket; and]

[(C) locking mechanisms must be installed on wheel(s) to prevent play outside the licensed authorized organization's licensed time(s).]

[(14) A manufacturer must include with each pull-tab bingo ticket deal instructions for how the pull-tab bingo ticket can be played in a manner consistent with the Bingo Enabling Act and this chapter. The instructions are not required to cover every potential method of playing the pull-tab bingo ticket deal.]

[(e) Sales and redemption.]

[(1) Instant pull-tab bingo tickets from a single deal may be sold by a licensed authorized organization over multiple occasions. A licensed authorized organization may bundle pull-tab bingo tickets of different form numbers and may sell those bundled pull-tab tickets. Pull-tab tickets may be sold up to one hour before an occasion, but they may only be redeemed during an occasion.]

[(2) Except as provided by paragraph (3) or (4) of this subsection, the event used to determine the winner(s) of an event pull-tab bingo ticket deal must occur during the same bingo occasion at which the first event pull-tab bingo ticket from that deal was sold. A winning event pull-tab ticket must be presented for payment during the same bingo occasion at which the event occurred.]

[(3) For a licensed authorized organization that conducts bingo through a unit created and operated under Texas Occupations Code, Subchapter I-1, any organization in the unit may sell or redeem event pull-tab tickets from a deal on the premises specified in their bingo licenses and during such licensed time on consecutive occasions within one 24-hour period.]

[(4) For a licensed authorized organization that conducts bingo on consecutive occasions within one day, the organization or organizations within a unit may sell or redeem event pull-tab tickets from a deal during either occasion and may account for and report all of the pull-tab bingo ticket sales and prizes for the occasions as sales and prizes for the final occasion.]

[(5) Licensed authorized organizations may not display or sell any pull-tab bingo ticket which has in any manner been marked, defaced, tampered with, or which otherwise may deceive the public or affect a person's chances of winning.]

[(6) A licensed authorized organization may not withdraw a deal of instant pull-tab bingo tickets from play until the entire deal is completely sold out or all winning instant pull-tab bingo tickets of $25.00 prize winnings or more have been redeemed, or the bingo occasion ends.]

[(7) A licensed authorized organization may not commingle different serial numbers of the same form number of pull-tab bingo tickets.]

[(8) A winning instant pull-tab bingo ticket must be presented for payment during the licensed authorized organization's bingo occasion(s) at which the instant pull-tab bingo ticket is available for sale.]

[(9) The licensed authorized organization's gross receipts from the sale of pull-tab bingo tickets must be included in the reported total gross receipts for the organization, except that an organization or organizations within a unit that conducts consecutive bingo occasions during one day may account for and report all of the pull-tab bingo ticket sales for the occasions as sales for the final occasion. An organization or unit that chooses to account for pull-tab bingo ticket sales for consecutive bingo occasions during one day as sales for the final occasion must also account for pull-tab bingo ticket prizes awarded over those occasions as prizes awarded for the final occasion. Each deal of pull-tab bingo tickets must be accounted for in sales, prizes or unsold cards.]

[(10) A licensed authorized organization may use video confirmation to display the results of an event ticket pull-tab bingo game(s). Video confirmation will have no effect on the play or results of any ticket or game.]

[(11) A licensed authorized organization must sell the pull-tab ticket for the price printed on the pull-tab ticket.]

[(12) Immediately upon payment of a winning pull-tab ticket of $25.00 or more, the licensed authorized organization must punch a hole with a standard hole punch through or otherwise mark or deface that winning pull-tab bingo ticket.]

[(f) Inspection. The Commission, its authorized representative or designee may examine and inspect any individual pull-tab bingo ticket or deal of pull-tab bingo tickets and may pull all remaining pull-tab bingo tickets in an unsold deal.]

[(g) Records.]

[~~(1) Any licensed authorized organization selling pull-tab bingo tickets must maintain a purchase log showing the date of the purchase, the form number and corresponding serial number of the purchased pull-tab bingo tickets.~~]

[~~(2) Licensed authorized organizations must show the sale of pull-tab bingo tickets, prizes that were paid and the form number and serial number of the pull-tab bingo tickets on the occasion cash report, except that an organization or organizations within a unit that conducts consecutive bingo occasions during one day may account for and report all of the pull-tab bingo ticket sales for the occasions as sales for the final occasion. An organization or unit that chooses to account for pull-tab bingo ticket sales for consecutive bingo occasions during one day as sales for the final occasion must also account for pull-tab bingo ticket prizes awarded over those occasions as prizes awarded for the final occasion. The aggregate total sales for the licensed authorized organization must be recorded on the cash register or point of sale station.~~]

[~~(3) Licensed authorized organizations must maintain a perpetual inventory of all pull-tab bingo games. They must account for all sold and unsold pull-tab bingo tickets and pull-tab bingo tickets designated for destruction. The licensed authorized organization will be responsible for the gross receipts and prizes associated with the unaccounted for pull-tab bingo tickets.~~]

[~~(4) As long as a specific pull-tab bingo game serial number is in play, all records, reports, receipts and redeemed winning pull-tab bingo tickets of $25.00 or more relating to this specific pull-tab bingo game serial number must be retained on the licensed premises for examination by the Commission.~~]

[~~(5) If a deal is removed from play and marked for destruction then all redeemed and unsold pull-tab bingo tickets of the deal must be retained by the licensed authorized organization for a period of four years from the date the deal is taken out of play or until the destruction of the deal is witnessed by the Commission, its authorized representative or designee.~~]

[~~(6) Manufacturers and distributors must provide the following information on each invoice and other document used in connection with a sale, return, or any type of transfer of pull-tab bingo tickets:~~]

[~~(A) date of sale;~~]

[~~(B) quantity sold;~~]

[~~(C) cost per each deal of pull-tab bingo game sold;~~]

[~~(D) form number and serial number of each pull-tab bingo game's deal;~~]

[~~(E) name and address of the purchaser; and~~]

[~~(F) Texas taxpayer number of the purchaser.~~]

[~~(7) All licensed organizations must retain these records for a period of four years.~~]

[~~(h) Style of Play. The following pull-tab bingo tickets are authorized by this rule. A last sale feature can be utilized on any pull-tab bingo ticket.~~]

[~~(1) Sign-up Board. A form of pull-tab bingo that is played with a sign-up board. Sign-up board tickets that contain a winning numeric, alpha or symbol instantly win the stated prize or qualify to advance to the sign-up board. The sign-up board that serves as the game flare is where identified winning sign-up board ticket holders may register for the opportunity to win the prize indicated on the sign-up board.~~]

[~~(2) Sign-up Board Ticket. A sign up board ticket is a form of pull-tab bingo played with a sign-up board. A single window or multiple windows sign-up board ticket reveals a winning (or losing) numeric, alpha or symbol that corresponds with the sign-up board.~~]

[~~(3) Tip Board. A form of pull-tab game where perforated tickets attached to a placard that have a predetermined winner under a seal.~~]

[~~(4) Coin Board. A placard that contains prizes consisting of coin(s). Coin boards can have a sign-up board as part of its placard.~~]

[~~(5) Coin Board Ticket. A form of pull-tab bingo that when opened reveals a winning number or symbol that corresponds with the coin board.~~]

[~~(6) Event Ticket. A form of pull-tab bingo that utilizes some subsequent action to determine the event ticket winner(s), such as a drawing of ball(s), spinning wheel, opening of a seal on a flare(s) or any other method approved by the Commission so long as that method has designated numbers, letters, or symbols that conform to the randomly selected numbers or symbols. When a flare is used to determine winning tickets, the flare shall have the same form number and serial number as the event tickets. Pull-tab bingo tickets used as event tickets must contain more than two instant winners.~~]

[~~(7) Instant Ticket. A form of pull-tab bingo that has predetermined winners and losers and has immediate recognition of the winners and losers.~~]

[~~(8) Multiple Part Event or Multiple Part Instant Ticket. A pull-tab bingo ticket that is broken apart and sold in sections by a licensed authorized organization. Each section of the ticket consists of a separate deal with its own corresponding payout structure, form number, serial number, and winner verification.~~]

[~~(9) Jackpot Pull-Tab Game. A style of pull-tab game that has a stated prize and a chance at a jackpot prize(s). A portion of the stated payout is contributed to the jackpot prize(s). Each jackpot is continuous for the same form number and continues until a jackpot prize(s) is awarded; provided that, any jackpot prize(s) must not exceed the statutory limits.~~]

[~~(10) Video Confirmation shall be subject to Commission approval.~~]

§402.324. Card-Minding Systems--Approval of Card-Minding Systems.

(a) A card-minding system must not be sold, leased, or otherwise furnished to any person for use in the conduct of bingo until it has first been tested and certified as compliant with the standards in this subchapter by an independent testing facility [~~or the Commission's own testing lab~~]. The card-minding system shall be submitted for testing at the manufacturer's expense. The testing facility should be required to ensure that the card-minding system conforms to the restrictions and conditions set forth in these standards. The approval process is set forth in subsections (b) - (f) of this section.

(b) Utilizing an Independent Testing Facility:

(1) - (5) (No change.)

(6) The Commission shall either approve or disapprove the submission based on the test results and inform the manufacturer and lab of the results within thirty (30) calendar days of receipt of the test results <u>and any other forms and documentation required to ensure the card-minding system is compliant with the standards in this subchapter</u>.

[~~(c) Utilizing the Commission's testing lab:~~]

[~~(1) Manufacturer has card-minding system ready for submission;~~]

[~~(2) Manufacturer submits system to Commission with letter outlining system specifics;~~]

[~~(3) Testing lab may request a demonstration of the system prior to testing;~~]

[~~(4) Lab performs validation testing to ensure compliance with Commission's requirements. This testing may include functional testing and/or modification testing, if applicable;~~]

[~~(5) Lab communicates with manufacturer on any questions arising from testing;~~]

[~~(6) Lab recommends approval or denial of the system within forty-five (45) calendar days from submission date; and~~]

[~~(7) The Commission issues an approval or denial letter to the manufacturer which includes software/firmware signatures (checksum).~~]

(c) [~~(d)~~] After the Commission approves a card-minding system, the manufacturer shall notify the Commission of the date, time and place of the first installation of the system so that a Commission representative may observe and review the card-minding system.

(d) [~~(e)~~] Checksum or digital signatures will be obtained from the proprietary software submitted for testing to be used to verify that proprietary software at playing locations is the same as the software that was approved. The manufacturer shall provide any software necessary to view the checksum or digital signatures.

(e) [~~(f)~~] The decision by the director to approve or disapprove any component of a card-minding system is administratively final.

(f) [~~(g)~~] The manufacturer shall be responsible for the costs related to the testing of card-minding systems [~~to include the fees charged by independent testing facilities or the Commission testing lab~~].

(g) [~~(h)~~] The manufacturer shall be responsible for the travel costs incurred by the Commission to audit the initial installation of a card-minding system in the state of Texas.

(h) [~~(i)~~] All card-minding system approvals issued by the Commission prior to the effective date of this section remain valid. Any subsequent changes or modifications to an approved system require compliance with this section.

§402.325. Card-Minding Systems--Licensed Authorized Organizations Requirements.

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

(d) The licensed authorized organization must treat void transactions resulting in a cash refund in the following manner:

(1) - (3) (No change.)

(4) All voided receipts, whether cash or other payment or as the result of presales, must be attached to the bingo occasion report printed at the end of each bingo occasion and maintained with the records.

(e) - (q) (No change.)

§402.326. Card-Minding Systems-Distributor Requirements.

(a) Installation. Each distributor that leases, sells, or otherwise furnishes a card-minding system shall install the system based on the manufacturer's approval letter for use in Texas. Each system shall be installed with:

(1) - (3) (No change.)

(4) [~~a dedicated modem phone line or~~] internet connectivity.

(b) - (h) (No change.)

§402.334. Shutter Card Bingo Systems - Approval of Shutter Card Bingo Systems.

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

(d) Checksum or digital signatures will be obtained from the proprietary software submitted for testing to be used to verify that proprietary software at playing locations is the same as the software that was approved. The manufacturer shall provide any software necessary to view the checksum or digital signatures.

(e) - (h) (No change.)

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Bob Biard
General Counsel
Texas Lottery Commission
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 344-5392

16 TAC §402.301, §402.303

The repeals are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.301. Bingo Card/Paper.

§402.303. Pull-tab or Instant Bingo Dispensers.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Texas Lottery Commission
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For further information, please call: (512) 344-5392

16 TAC §§402.301 - 402.311

The new rules are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to

adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.301. Approval of Pull-Tab Bingo Tickets.

(a) Approval of Pull-Tab Bingo Tickets.

(1) A pull-tab bingo ticket may not be sold in the state of Texas, nor furnished to any person in this state nor used for play in this state until that pull-tab bingo ticket has received approval for use within the state of Texas by the Commission. The manufacturer at its own expense must present its pull-tab bingo ticket to the Commission for approval.

(2) All pull-tab bingo ticket color artwork with a letter of introduction including style of play must be presented to the Commission's Austin, Texas location for review. The manufacturer must submit one complete color positive or hardcopy set of the color artwork for each pull-tab bingo ticket and its accompanying flare. The color artwork may be submitted in an electronic format prescribed by the Commission in lieu of the hardcopy submission. The submission must include the payout schedule. The submission must show both sides of a pull-tab bingo ticket and must be submitted on an 8 1/2" x 11" size sheet. The color artwork will show the actual size of the ticket and a 200% size of the ticket. The color artwork will clearly identify all winning and non-winning symbols. The color artwork will clearly identify the winnable patterns and combinations.

(3) The color artwork for each individual pull-tab bingo ticket must:

(A) display in no less than 26-point diameter circle, an impression of the Commission's seal with the words "Texas Lottery Commission" engraved around the margin and a five-pointed star in the center;

(B) contain the name of the game in a conspicuous location on the pull-tab bingo ticket;

(C) contain the form number assigned by the manufacturer in a conspicuous location on the pull-tab bingo ticket;

(D) contain the manufacturer's name or trademark in a conspicuous location on the pull-tab bingo ticket;

(E) disclose the prize amount and number of winners for each prize amount, the number of individual pull-tab bingo tickets contained in the deal, and the cost per pull-tab bingo ticket in a conspicuous location on the pull-tab bingo ticket;

(F) display the serial number where it will be printed in a conspicuous location on the pull-tab bingo ticket. The color artwork may display the word "sample" or number "000000" in lieu of the serial number;

(G) contain graphic symbols that preserve the integrity of the Commission. The Commission will not approve any pull-tab bingo ticket that displays images or text that could be interpreted as depicting violent acts, profane language, or provocative, explicit, or derogatory images or text, as determined by the Commission. All images or text are subject to final approval by the Commission; and

(H) be accompanied with the color artwork of the pull-tab bingo tickets along with a list of all other colors that will be printed with the game.

(4) Upon approval of the color artwork, the manufacturer may be notified by the Commission to submit a specified number of tickets for testing. The tickets must be submitted for testing to the Commission at the manufacturer's own expense. If necessary, the Commission may request that additional tickets or a deal be submitted for testing.

(5) If the color artwork is approved and the pull-tab bingo tickets pass the Commission's testing, the manufacturer will be notified of the approval. This approval only extends to the specific pull-tab bingo game and the specific form number cited in the Commission's approval letter. If the pull-tab bingo ticket is modified in any way, with the exception of the serial number, index color, or trademark(s), it must be resubmitted to the Commission for approval. Changes to symbols require only an artwork approval from the Commission.

(6) The Commission may require resubmission of an approved pull-tab bingo ticket at any time.

(b) Disapproval of Pull-Tab Bingo Tickets.

(1) Upon inspection of a pull-tab bingo ticket by the Commission, if it is deemed not to properly preserve the integrity or security of the Commission including compliance with the art work requirements of this rule, the Commission may disapprove a pull-tab bingo ticket. All pull-tab bingo tickets that are disapproved by the Commission will cease to be allowed for sale until such time as the manufacturer complies with the written instructions of the Commission, or until any discrepancies are resolved. Disapproval of and prohibition to use, purchase, sell or otherwise distribute such a pull-tab bingo ticket is effective immediately upon notice to the manufacturer by the Commission. Upon receipt of such notice, the manufacturer must immediately notify the distributor and the distributor must immediately notify affected licensed authorized organizations to cease all use, purchase, sale or other distribution of the disapproved pull-tab ticket. The distributor must provide to the Commission, within 15 days of the Commission's notice to the manufacturer, confirmation that the distributor has notified the licensed authorized organization that the pull-tab ticket has been disapproved and sale and use of the disapproved ticket must cease immediately.

(2) If modified by the manufacturer all disapproved pull-tab bingo tickets may be resubmitted to the Commission. No sale of disapproved tickets will be allowed until the resubmitted tickets have passed security testing by the Commission. At any time the manufacturer may withdraw any disapproved pull-tab bingo tickets from further consideration.

(3) The Commission may disapprove a pull-tab bingo game at any stage of review, which includes artwork review and security testing, or at any time in the duration of a pull-tab bingo game. The disapproval of a pull-tab bingo ticket is administratively final.

§402.302. Pull-Tab Bingo Manufacturing Requirements.

Manufacturing Requirements.

(1) Manufacturers of pull-tab bingo tickets must manufacture, assemble, and package each deal in such a manner that none of the winning pull-tab bingo tickets, nor the location, or approximate location of any winning pull-tab bingo ticket can be determined in advance of opening the deal by any means or device. Nor should the winning pull-tab bingo tickets, or the location or approximate location of any winning pull-tab bingo ticket be determined in advance of opening the deal by manufacture, printing, color variations, assembly, packaging markings, or by use of a light. Each manufacturer is subject to inspection by the Commission, its authorized representative, or designee.

(2) All winning pull-tab bingo tickets as identified on the payout schedule must be randomly distributed and mixed among all other pull-tab bingo tickets of the same serial number in a deal regardless of the number of packages, boxes, or other containers in which the deal is packaged. The position of any winning pull-tab bingo ticket of

the same serial numbers must not demonstrate a pattern within the deal or within a portion of the deal. If a deal of pull-tabs is packed in more than one box or container, no individual container may indicate that it includes a winner or contains a disproportionate share of winning or losing tickets.

(3) Each deal's package, box, or other container shall be sealed at the manufacturer's factory with a seal including a warning to the purchaser that the deal may have been tampered with if the package, box, or other container was received by the purchaser with the seal broken.

(4) Each deal's serial number shall be clearly and legibly placed on the outside of the deal's package, box or other container or be able to be viewed from the outside of the package, box or container.

(5) A flare must accompany each deal.

(6) The information contained in subsection (a)(3)(A), (B), (C), (D), and (F) of this section shall be located on the outside of each deal's sealed package, box, or other container.

(7) Manufacturers must seal or tape, with tamper resistant seal or tape, every entry point into a package, box or container of pull-tab bingo tickets prior to shipment. The seal or tape must be of such construction as to guarantee that should the container be opened or tampered with, such tampering or opening would be easily discernible.

(8) All high tier winning instant pull-tab bingo tickets must utilize a secondary form of winner verification.

(9) Each individual pull-tab bingo ticket must be constructed so that, until opened by a player, it is substantially impossible, in the opinion of the Commission, to determine its concealed letter(s), number(s) or symbol(s).

(10) No manufacturer may sell or otherwise provide to a distributor and no distributor may sell or otherwise provide to a licensed authorized organization of this state or for use in this state any pull-tab bingo game that does not contain a minimum prize payout of 65% of total receipts if completely sold out.

(11) A manufacturer in selling or providing pull-tab bingo tickets to a distributor shall seal or shrink-wrap each package, box, or container of a deal completely in a clear wrapping material.

(12) Pull-tab bingo tickets must:

(A) be constructed of cardboard and glued or otherwise securely sealed along all four edges of the pull-tab bingo ticket and between the individual perforated break-open tab(s) on the ticket. The glue must be of sufficient strength and type so as to prevent the separation of the sides of a pull-tab bingo ticket;

(B) have letters, numbers or symbols that are concealed behind perforated window tab(s), and allow such letters, numbers or symbols to be revealed only after the player has physically removed the perforated window tab(s);

(C) prevent the determination of a winning or losing pull-tab bingo ticket by any means other than the physical removal of the perforated window tab(s) by the player;

(D) be designed so that the numbers and symbols are a minimum of 2/32 (4/64) inch from the dye-cut window perforations;

(E) be designed so that the lines or arrows that identify the winning symbol combinations will be a minimum of 5/32 inch from the open edge farthest from the hinge of the dye-cut window perforations;

(F) be designed so that highlighted "pay-code" designations that identify the winning symbol combinations will be a minimum of 3.5/32 (7/64) inch from the dye-cut window perforations;

(G) be designed so that secondary winner protection codes appear in the left margin of the ticket, unless the secondary winner protection codes are randomly generated serial number-type winner protection codes. Randomly generated serial number-type winner protection codes will be randomly located in either the left or middle column of symbols and will be designed so that the numbers are a minimum of 3.5/32 (7/64) inch from the dye-cut window perforations. Any colored line or bar or background used to highlight the winner protection code will be a minimum 3.5/32 (7/64) inch from the dye-cut window perforations;

(H) have the Commission's seal placed on all pull-tab bingo tickets by only a licensed manufacturer; and

(I) be designed so that the name of the manufacturer or its distinctive logo, form number and serial number unique to the deal, name of the game, price of the ticket, and the payout structure remain when the letters, numbers, and symbols are revealed.

(13) Wheels must be submitted to the Commission for approval. As a part of the approval process, the following requirements must be demonstrated to the satisfaction of the Commission:

(A) wheels must be able to spin at least four times with reasonable effort;

(B) wheels must only contain the same number or symbols as represented on the event ticket; and

(C) locking mechanisms must be installed on wheel(s) to prevent play outside the licensed authorized organization's licensed time(s).

(14) A manufacturer must include with each pull-tab bingo ticket deal instructions for how the pull-tab bingo ticket can be played in a manner consistent with the Bingo Enabling Act and this chapter. The instructions are not required to cover every potential method of playing the pull-tab bingo ticket deal.

§402.303. Pull-Tab Bingo Sales and Redemption.

Sales and Redemption.

(1) Instant pull-tab bingo tickets from a single deal may be sold by a licensed authorized organization over multiple occasions. A licensed authorized organization may bundle pull-tab bingo tickets of different form numbers and may sell those bundled pull-tab tickets. Pull-tab tickets may be sold up to one hour before an occasion, but they may only be redeemed during an occasion.

(2) Except as provided by paragraph (3) or (4) of this subsection, the event used to determine the winner(s) of an event pull-tab bingo ticket deal must occur during the same bingo occasion at which the first event pull-tab bingo ticket from that deal was sold. A winning event pull-tab ticket must be presented for payment during the same bingo occasion at which the event occurred.

(3) For a licensed authorized organization that conducts bingo through a unit created and operated under Texas Occupations Code, Subchapter I-1, any organization in the unit may sell or redeem event pull-tab tickets from a deal on the premises specified in its bingo license and during such licensed time on consecutive occasions within one 24-hour period.

(4) For a licensed authorized organization that conducts bingo on consecutive occasions within one day, the organization or organizations within a unit may sell or redeem event pull-tab tickets from a deal during either occasion and may account for and report all

of the pull-tab bingo ticket sales and prizes for the occasions as sales and prizes for the final occasion.

(5) Licensed authorized organizations may not display or sell any pull-tab bingo ticket which has in any manner been marked, defaced, tampered with, or which otherwise may deceive the public or affect a person's chances of winning.

(6) A licensed authorized organization may not withdraw a deal of instant pull-tab bingo tickets from play until the entire deal is completely sold out or all winning instant pull-tab bingo tickets of $25.00 prize winnings or more have been redeemed, or the bingo occasion ends.

(7) A licensed authorized organization may not commingle different serial numbers of the same form number of pull-tab bingo tickets.

(8) A winning instant pull-tab bingo ticket must be presented for payment during the licensed authorized organization's bingo occasion(s) at which the instant pull-tab bingo ticket is available for sale.

(9) The licensed authorized organization's gross receipts from the sale of pull-tab bingo tickets must be included in the reported total gross receipts for the organization, except that an organization or organizations within a unit that conducts consecutive bingo occasions during one day may account for and report all of the pull-tab bingo ticket sales for the occasions as sales for the final occasion. An organization or unit that chooses to account for pull-tab bingo ticket sales for consecutive bingo occasions during one day as sales for the final occasion must also account for pull-tab bingo ticket prizes awarded over those occasions as prizes awarded for the final occasion. Each deal of pull-tab bingo tickets must be accounted for in sales, prizes or unsold cards.

(10) A licensed authorized organization may use video confirmation to display the results of an event ticket pull-tab bingo game(s). Video confirmation will have no effect on the play or results of any ticket or game.

(11) A licensed authorized organization must sell the pull-tab ticket for the price printed on the pull-tab ticket.

(12) Immediately upon payment of a winning pull-tab ticket of $25.00 or more, the licensed authorized organization must punch a hole with a standard hole punch through or otherwise mark or deface that winning pull-tab bingo ticket.

§402.304. Pull-Tab Bingo Record Keeping.

(a) Inspection. The Commission, its authorized representative or designee may examine and inspect any individual pull-tab bingo ticket or deal of pull-tab bingo tickets and may pull all remaining pull-tab bingo tickets in an unsold deal.

(b) Records.

(1) Any licensed authorized organization selling pull-tab bingo tickets must maintain a purchase log showing the date of the purchase, the form number and corresponding serial number of the purchased pull-tab bingo tickets.

(2) Licensed authorized organizations must show the sale of pull-tab bingo tickets, prizes that were paid and the form number and serial number of the pull-tab bingo tickets on the occasion cash report, except that an organization or organizations within a unit that conducts consecutive bingo occasions during one day may account for and report all of the pull-tab bingo ticket sales for the occasions as sales for the final occasion. An organization or unit that chooses to account for pull-tab bingo ticket sales for consecutive bingo occasions during one day as sales for the final occasion must also account for pull-tab bingo ticket prizes awarded over those occasions as prizes awarded for the final occasion. The aggregate total sales for the licensed authorized organization must be recorded on the cash register or point of sale station.

(3) Licensed authorized organizations must maintain a perpetual inventory of all pull-tab bingo games. They must account for all sold and unsold pull-tab bingo tickets and pull-tab bingo tickets designated for destruction. The licensed authorized organization will be responsible for the gross receipts and prizes associated with the unaccounted for pull-tab bingo tickets.

(4) As long as a specific pull-tab bingo game serial number is in play, all records, reports, receipts and redeemed winning pull-tab bingo tickets of $25.00 or more relating to this specific pull-tab bingo game serial number must be retained on the licensed premises for examination by the Commission.

(5) If a deal is removed from play and marked for destruction then all redeemed and unsold pull-tab bingo tickets of the deal must be retained by the licensed authorized organization for a period of four years from the date the deal is taken out of play or until the destruction of the deal is witnessed by the Commission, its authorized representative or designee.

(6) Manufacturers and distributors must provide the following information on each invoice and other document used in connection with a sale, return, or any type of transfer of pull-tab bingo tickets:

(A) date of sale;

(B) quantity sold;

(C) cost per each deal of pull-tab bingo game sold;

(D) form number and serial number of each pull-tab bingo game's deal;

(E) name and address of the purchaser; and

(F) Texas taxpayer number of the purchaser.

(7) All licensed organizations must retain these records for a period of four years.

§402.305. Pull-Tab Bingo Styles of Play.

The following pull-tab bingo tickets are authorized by this rule. A last sale feature can be utilized on any pull-tab bingo ticket.

(1) Sign-up Board. A form of pull-tab bingo that is played with a sign-up board. Sign-up board tickets that contain a winning numeric, alpha or symbol instantly win the stated prize or qualify to advance to the sign-up board. The sign-up board that serves as the game flare is where identified winning sign-up board ticket holders may register for the opportunity to win the prize indicated on the sign-up board.

(2) Sign-up Board Ticket. A sign up board ticket is a form of pull-tab bingo played with a sign-up board. A single window or multiple windows sign-up board ticket reveals a winning (or losing) numeric, alpha or symbol that corresponds with the sign-up board.

(3) Tip Board. A form of pull-tab game where perforated tickets attached to a placard that have a predetermined winner under a seal.

(4) Coin Board. A placard that contains prizes consisting of coin(s). Coin boards can have a sign-up board as part of its placard.

(5) Coin Board Ticket. A form of pull-tab bingo that when opened reveals a winning number or symbol that corresponds with the coin board.

(6) Event Ticket. A form of pull-tab bingo that utilizes some subsequent action to determine the event ticket winner(s), such as a drawing of ball(s), spinning wheel, opening of a seal on a flare(s) or any other method approved by the Commission so long as that method has designated numbers, letters, or symbols that conform to the randomly selected numbers or symbols. When a flare is used to determine winning tickets, the flare shall have the same form number and serial number as the event tickets. Pull-tab bingo tickets used as event tickets must contain more than two instant winners.

(7) Instant Ticket. A form of pull-tab bingo that has predetermined winners and losers and has immediate recognition of the winners and losers.

(8) Multiple Part Event or Multiple Part Instant Ticket. A pull-tab bingo ticket that is broken apart and sold in sections by a licensed authorized organization. Each section of the ticket consists of a separate deal with its own corresponding payout structure, form number, serial number, and winner verification.

(9) Jackpot Pull-Tab Game. A style of pull-tab game that has a stated prize and a chance at a jackpot prize(s). A portion of the stated payout is contributed to the jackpot prize(s). Each jackpot is continuous for the same form number and continues until a jackpot prize(s) is awarded; provided that, any jackpot prize(s) must not exceed the statutory limits.

(10) Video Confirmation shall be subject to Commission approval.

§402.306. Bingo Card/Paper Definitions.

The following words and terms, shall have the following meaning unless the context clearly indicates otherwise:

(1) Bingo card/paper. A hard card, disposable bingo card/paper, shutter card, or any other bingo card/paper approved by the Commission.

(2) Bingo hard card. A device made of cardboard, plastic or other suitable material that is intended for repeated use of the bingo card at multiple bingo occasions.

(3) Bonus number(s). A number or numbers on any type of bingo card/paper which when called could result in an additional prize awarded. Bonus number(s) must be announced prior to the start of a bingo game.

(4) Braille bingo card. A device that contains raised symbols that reflect numbers on a reusable card.

(5) Break-open bingo. A type of disposable bingo card/paper that is sealed, that conceals the bingo card/paper face, that may be folded, and where the bingo game or a portion of the bingo game may have been pre-called.

(6) Case. A receptacle that contains bingo card/paper products.

(7) Cut. Indicates the direction in which a sheet of faces will be cut from the master sheet of disposable bingo card/paper. A cut can be square, horizontal or vertical. The sheet of disposable bingo card/paper printed by the manufacturer of a specific group of disposable bingo card/paper that can be subdivided vertically or horizontally into sheets.

(8) Defective. Bingo card/paper missing specifications as originally approved by the Commission.

(9) Disposable bingo card/paper. A sheet or sheets of paper that is designed or intended for use at a single bingo occasion.

(10) Double numbers. Bingo card/paper with two numbers in each of the 24 spaces on each face.

(11) Face. A specific configuration of numbers, symbols, or blank squares imprinted on paper, cardboard, or other materials, and designed to be used to conduct bingo games. The bingo card/paper normally consists of five rows of five columns that may bear 24 preprinted numbers between 1 and 75, symbols, or blank squares, except for the center square which is a free space and have the letters B-I-N-G-O appear in order above the five columns.

(12) Free space. The center square on the face of a bingo card/paper.

(13) Loteria. A type of bingo that utilizes symbols or pictures. Normally playing cards are utilized instead of numbered balls.

(14) Multi-part card/paper. A type of disposable bingo card/paper where the player selects the numbers. The player retains one part of the disposable bingo card/paper while the licensee for the purpose of verification retains the other part of the disposable bingo card/paper.

(15) On. The number of faces imprinted on a sheet of disposal bingo card/paper after it is cut. The number of bingo card/paper faces normally precedes this term.

(16) Pre-marked. A bingo card/paper where one or more of the numbers are already marked or identified prior to the start of the game.

(17) Product line. A specific type of bingo card/paper, identifiable by features or characteristics that are unique when compared to other bingo card/paper manufactured by the manufacturer.

(18) Serial number. The unique identification number assigned by the manufacturer to a specific product line of bingo card/paper.

(19) Series number. The specific number assigned by the manufacturer that identifies the unique configuration of numbers that appears on an individual bingo card/paper face.

(20) Sheet. A single piece of paper that contains one or more disposable bingo card/paper faces.

(21) Shutter card. A device made of cardboard or other suitable material with plastic "shutters" that cover a number to simulate the number being daubed.

(22) UP. The number of sheets of disposable bingo paper glued together by the manufacturer. The number of sheets normally precedes this term.

(23) UPS pads. A bound collection of disposable bingo card/paper where each sheet in the collection is used to play a separate bingo game during the occasion.

§402.307. Bingo Card/Paper Approval.

(a) Approval of Bingo Card/Paper.

(1) Bingo card/paper shall not be sold in the state of Texas, nor furnished to any person in this state, nor used for play in this state until the manufacturer of the bingo card/paper has received written approval for use within the state of Texas by the Commission. The manufacturer at its own expense must present the bingo card/paper to the Commission for approval.

(2) A letter of introduction including the style of play must be presented to Commission headquarters for review. The manufacturer must submit one complete color positive or sample for each type of bingo card/paper. The color positive or sample may be submitted in

an electronic format prescribed by the Commission in lieu of the hard-copy submission. The color positive or sample bingo card/paper must:

(A) bear on the face of every disposable bingo card/paper used, sold, or furnished in this state an impression of the State of Texas and a star of five points encircled by olive and live oak branches and the words "Texas Lottery Commission," in accordance with detailed specification, available on request from the Commission. The face of each disposable bingo card/paper must also have printed on it in a conspicuous location the name of the manufacturer or trademark, which has been filed with the Commission; and

(B) contain the serial and series numbers assigned by the manufacturer on the face of each of the bingo card/paper, except in the case of Break-open bingo, which may contain the serial number assigned by the manufacturer on the outside so as not to be concealed.

(3) The bingo card/paper may contain numbers or symbols so long as the numbers or symbols preserve the integrity of the Commission. The Commission will not approve any bingo paper that displays images or text that could be interpreted as depicting violent acts, profane language, or provocative, explicit, or derogatory images or text, as determined by the Commission. All images or text are subject to final approval by the Commission.

(4) If the bingo card/paper is approved the manufacturer will be notified of the approval. This approval only extends to the specific bingo card/paper submitted and will be cited in the Commission's approval letter. If the bingo card/paper is modified in any way, with the exception of the color, series number, and/or serial number it must be resubmitted to the Commission for approval.

(5) The Commission may require resubmission of an approved bingo card/paper at any time.

(6) If an approved bingo card/paper is discontinued or no longer manufactured for sale in Texas, the manufacturer must provide the Commission written notification within ten days of discontinuance or cessation of manufacturing for sale in Texas. The written notification may be sent to the Commission via facsimile, e-mail, delivery services or postal delivery.

(b) Disapproval of Bingo Card/Paper.

(1) After inspection of the bingo card/paper by the Commission, if the bingo card/paper does not comply with the provisions of this rule and/or the Bingo Enabling Act, the Commission shall disapprove the bingo card/paper and shall notify the manufacturer of the disapproval. Any bingo card/paper that is disapproved by the Commission may not be displayed, purchased or sold in the state of Texas. Disapproval of and prohibition to use, purchase, sell or otherwise distribute, is effective immediately upon notice to the manufacturer by the Commission.

(2) A manufacturer shall not sell, or furnish unapproved bingo card/paper to anyone, including another manufacturer or distributor for use in this state. A manufacturer shall not sell, or furnish bingo card/paper not bearing the seal of the Commission on the face of the bingo card/paper and the manufacturer's name or trademark to distributors for use in this state. This requirement also applies to any manufacturer who assembles bingo card/paper for sale in Texas.

(3) A licensed authorized organization shall not purchase, obtain, or use disapproved bingo card/paper in this state.

(4) If the manufacturer modifies the bingo card/paper that was previously disapproved, the manufacturer may resubmit the modified bingo card/paper for Commission approval. At any time the manufacturer may withdraw any disapproved bingo card/paper from further consideration.

(5) The Commission may disapprove the bingo card/paper at any stage of review. The disapproval of the bingo card/paper is administratively final.

§402.308. Bingo Card/Paper Manufacturing Requirements.
Manufacturing Requirements.

(1) Bingo card/paper must comply with the following construction standards.

(A) The disposable paper used shall be of sufficient weight and quality to allow for clearly readable numbers and to prevent ink from spreading or bleeding through an UPS pad thereby obscuring other numbers or bingo card/paper;

(B) series numbers may be displayed in the center square of the bingo card/paper;

(C) numbers printed on the bingo card/paper shall be randomly assigned; and

(D) a manufacturer shall not repeat a serial number on or in the same product line, series, and color of bingo card/paper within one year of the last printing of that serial number.

(2) UPS pad must comply with the following construction standards.

(A) Bingo card/paper in UPS pads must only be glued and not stapled; and

(B) the disposable bingo card/paper assembled into UPS pads shall not be separated, with the exception of the multi-part disposable bingo card/paper, nor shall single sheets already manufactured be cut for sale for special bingo games.

(3) Inspection. The Commission, its authorized representative or designee may examine and inspect any individual bingo card/paper or series of bingo card/paper and may pull all remaining bingo card/paper in the inventory if the Commission, its authorized representative or designee determines that the bingo card/paper is defective or has not been approved.

(4) Packaging.

(A) Bingo card/paper shall be sealed in shrink wrap and be designed so that if the shrink wrapped bingo card/paper, package, or case was opened or tampered with, it would be easily noticed.

(B) Barcodes may be included on each bingo card/paper, package, or case provided the barcode contains information required in subparagraph (C).

(C) A label shall be placed on, or be visible from, the exterior of each package or case of bingo card/paper listing the following information:

(i) Type of product;

(ii) Series number of the UPS pads and/or sheet(s);

(iii) Serial numbers of the top sheet of the UPS pads and/or sheet(s);

(iv) Number of package or cases; and

(v) Cut and color of paper.

(D) A packing slip shall be included with the package or case listing the following information:

(i) Type of product;

(ii) Number of UPS pads or sheets;

(iii) Series number of the UPS pads and/or sheet(s);

(iv) Serial numbers of the top sheet of the UPS pads and/or sheet(s);

(v) Number of package or cases; and

(vi) Cut and color of paper.

§402.309. Bingo Card/Paper Record Keeping.

Records.

(1) Manufacturers and distributors must provide the following information on each invoice and other documents used in connection with a sale, return or any other type of transfer of bingo card/paper:

(A) Date of sale;

(B) Quantity sold and number of faces per sheet;

(C) Serial and series number of each bingo card/paper sold;

(D) Name and address of the purchaser; and

(E) Texas taxpayer identification number of the purchaser.

(2) Manufacturers and distributors must maintain standard accounting records that include but are not limited to:

(A) Sales invoice;

(B) Credit memos;

(C) Sales journal; and

(D) Purchase records.

(3) Licensed authorized organization.

(A) A licensed authorized organization must maintain a disposable bingo card/paper sales summary showing the organization's name, taxpayer number, distributor's taxpayer number, invoice date, distributor's name, invoice number, serial number, and series number. Also, the disposable bingo card/paper sales summary must include the number of faces (ON), number of sheets (UP), and color of borders.

(B) A licensed authorized organization must show the date of the occasion on which the disposable bingo card/paper was sold, a beginning inventory, along with the number of disposable bingo card/paper sold.

(C) A licensed authorized organization must maintain a perpetual inventory of all disposable bingo card/paper.

(D) Disposable bingo card/paper marked for destruction cannot be destroyed until witnessed by the Commission, its authorized representative or designee. All destruction documentation must be retained by the licensed organization for a period of four years from the date of destruction.

(4) All records identified in this subsection must be retained for a period of four years from creation of the records.

§402.310. Bingo Card/Paper Styles of Play.

(a) Braille Cards. Braille cards are bingo equipment as defined by Occupations Code, §2001.002(5) and must be approved by the Commission. Players may not use their own personal braille cards.

(b) Loteria. The symbols or pictures may be identified with Spanish subtitles and each of the 54 cards contains a separate and distinct symbol or picture. The 54 individual cards may be shuffled by the caller and then randomly drawn and announced to the players. The player uses a loteria card, which contains a minimum of sixteen squares and each square has one of the 54 symbols or pictures. There are no duplicate symbols or pictures on the loteria card. Loteria cards are bingo equipment as defined by Occupations Code, §2001.002(5) and must be approved by the Commission.

(c) Style of Play and Minimum Standards of Play. Prizes awarded on any style of play must be in accordance with Occupations Code, §2001.420.

(1) Player pick ems. A game of bingo where a player selects his/her own numbers on a multi-part duplicated disposable bingo card/paper. One copy is retained by the player and used as a bingo card/paper while the other copy is provided to the organization for verification purposes.

(2) Progressive bingo. A game of bingo that either the established prize amount or number of bingo balls and/or objects may be increased from one session to the next scheduled session. If no player completes the required pattern within the specified number of bingo balls or objects drawn, the established prize amount may be increased but shall not exceed the prize amount authorized by the Bingo Enabling Act.

(3) Warm-up or early bird. A bingo game conducted at the beginning of a bingo occasion during the authorized organization's license times, in which prizes are awarded based upon a percentage of the sum of money received from the sale of the warm-up/early bird bingo card/paper.

(4) Shaded/Images bingo. Bingo card/paper that incorporates images where one or more squares on a bingo card/paper face are shaded. Each shaded image conforms to a pattern that must be achieved to win a bingo game or each shaded square may be used as a free space or a pattern for a bingo game.

(5) Bingo bonus number(s). A bingo game that has additional identified number(s) in excess of the 24 numbers that appear on the bingo card/paper face that, when called, could result in an additional prize awarded. The first player who matches the numbers shown on the bonus number(s) line within the specified number(s) called wins the additional prize.

(6) Multi level or multi tier. Bingo card/paper that has one or more additional lines of number(s) aside from the normal five lines that when played could result in an additional prize. Therefore, a multi level or multi tiered game could be played on this bingo card/paper that provides more opportunities to win.

(7) Multi color bingo. A bingo game played on a bingo card/paper with a different color for each bingo card/paper face. Prizes are awarded based on the color on which the bingo card/paper face that had the bingo.

(8) Pre-called. A game of bingo where the numbers for the game have been pre-called and identified prior to the start of the game.

(9) Double number. A bingo game played on a bingo card/paper that has two numbers per square. A player has two chances to daub each square.

(10) Break-open bingo. A type of bingo game played on sealed disposable bingo card/paper, where the bingo card/paper face is concealed, that may be folded, and where the bingo game has been pre-called. The bingo game may be pre-called prior to the authorized organization's license time.

(11) Regular bingo. A bingo game played on the standard card face of five rows by five columns with 24 pre-printed numbers

between 1 and 75, symbols, or blank squares and a free space square where the winner is determined by a predetermined pattern.

(d) Promotional Bingo. This rule shall not apply to bingo card/paper furnished for use in a promotional bingo game conducted in accordance the Occupations Code, §2001.551. The card/paper may not contain the Commission seal.

(e) Exempt Organization. This rule shall not apply to bingo card/paper furnished for use by an organization receiving an exemption from bingo licensing in accordance with the Occupations Code, §§2001.551(b)(3)(A) and (B). The bingo card/paper may not contain the Commission seal.

(f) House Rules. A licensed authorized organization playing a style of bingo other than regular bingo must develop house rules on how the game is played. The house rules must be made available to the public.

(g) Card-Minding Devices. This rule shall be applicable only to bingo card/paper made of paper, cardboard or similar material approved by the Commission and shall not be applicable to the manufacture or use of card-minding devices addressed in §§402.321 - 402.328 of this chapter, with the exception of style of play as defined by this rule and approved by the Commission.

§402.311. Pull-Tab or Instant Bingo Dispensers.

(a) Approval of Pull-Tab or Instant Bingo Dispensers.

(1) No pull-tab or instant bingo dispenser may be sold, leased, or otherwise furnished to any person in this state or used in the conduct of bingo for public play unless and until a dispenser which is identical to the dispenser intended to be sold, leased, or otherwise furnished has first been presented to the Commission by its manufacturer, at the manufacturer's expense, and has been approved by the Commission for use within the state.

(2) An identical dispenser to the dispenser intended to be sold, leased, or otherwise furnished must be presented to the Commission in Austin, Texas for review. If granted, approval extends only to the specific dispenser model approved. Any modification must be approved by the Commission.

(3) Once a dispenser has been approved, the Commission may keep the dispenser for further testing and evaluation for as long as the Commission deems necessary.

(b) Manufacturing Requirements.

(1) Manufacturers of pull-tab or instant bingo dispensers must manufacture each dispenser in such a manner to ensure that the dispenser dispenses a break-open bingo ticket, an instant bingo ticket, a pull-tab bingo game or instant bingo card only after the player inserts money into the dispenser, and that such ticket, game or card is the sole thing of value which may be redeemed for cash.

(2) Manufacturers of dispensers must manufacture each dispenser in such a manner to ensure that the device neither displays nor has the capability to determine whether a break-open bingo ticket, an instant bingo ticket, or a pull-tab bingo game is a winning or non-winning ticket.

(3) Manufacturers of dispensers must manufacture each dispenser in such a manner that any visual animation does not simulate or display rolling or spinning reels.

(4) Manufacturers of dispensers must manufacture each dispenser in such a manner that any stacking column is adjustable for varying lengths of break-open bingo tickets, instant bingo tickets, or pull-tab bingo games. As an option, a dispenser may use replaceable stacking columns that accommodate varying lengths of break-open bingo tickets, instant bingo tickets, or pull-tab bingo games. The dispenser must be adjustable for varying thicknesses of break-open tickets, instant bingo tickets, or pull-tab bingo games.

(5) If the Commission detects or discovers any problem with the dispenser that affects the security and/or integrity of the break-open bingo ticket, an instant bingo ticket, or a pull-tab bingo game or dispenser, the Commission may direct the manufacturer, distributor, or conductor to cease the sale, lease, or use of the dispenser, as applicable. The Commission may require the manufacturer to correct the defect, malfunction, or problem or recall the dispenser immediately upon notification by the Commission to the manufacturer. If the manufacturer, distributor, or conductor detects or discovers any defect, malfunction, or problem with the dispenser, the manufacturer, distributor, or conductor, as applicable, shall immediately remove the dispenser from use or play and immediately notify the Commission of such action.

(c) Conductor Requirements.

(1) A conductor who has purchased or leased a dispenser may not allow another conductor to use such dispenser unless and until the former conductor has removed its break-open bingo tickets, instant bingo tickets, pull-tab bingo games and instant bingo cards from the dispenser.

(2) Each conductor who uses a dispenser at its bingo occasion shall affix to the dispenser an identification label which displays the conductor's name and Texas taxpayer identification number.

(3) The keys to open the locked doors to the dispenser's ticket dispensing area and coin and/or cash box must be in the possession and control of the operator in charge of the occasion, or someone designated by the operator. The operator in charge or the person designated shall present the keys to a Commission representative immediately upon request. The operator in charge shall be responsible for ensuring that the person so designated shall have the keys available at all times during the occasion.

(4) All break-open bingo tickets, instant bingo tickets, pull-tab bingo games or instant bingo cards in any one column or sleeve must have the same serial number, color description, and must be of the same kind and type.

(d) Inspection. The Commission or the Commission's authorized representative(s) may examine and inspect any individual pull-tab or instant bingo dispenser. Such examination and inspection includes immediate access to the dispenser and unlimited inspection of all parts of the dispenser.

(e) Records.

(1) All records, reports, and receipts relating to the pull-tab or instant bingo dispenser sales, maintenance, and repairs must be retained by the conductor on the premises where the conductor is licensed to conduct bingo or at a location designated in writing by the conductor for a period of four years for examination by the Commission. Any change in the designated location must be submitted to the Commission in writing at least ten days prior to the change.

(2) Manufacturers and distributors must provide and maintain for a period of four years the following information on each invoice or other document used in connection with a sale or lease, as applicable:

(A) date of sale or lease;

(B) quantity sold or leased;

(C) cost per dispenser;

(D) model and serial number of each dispenser;

(E) name and address of the purchaser or lessee; and

(F) Texas taxpayer identification number of the purchaser or lessee.

(f) Restrictions. No licensee may display, use or otherwise furnish a dispenser which has in any manner been marked, defaced, tampered with, or which otherwise may deceive the public or affect a person's chances of winning.

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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Bob Biard
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SUBCHAPTER D. LICENSING REQUIREMENTS

16 TAC §§402.400 - 402.402, 402.404, 402.411, 402.443

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.400. General Licensing Provisions.

(a) - (d) (No change.)

(e) If an application is incomplete, the Commission will notify the applicant and, if applicable, the applicant's bingo hall. The applicant must provide the requested information within 21 calendar days of such notification. Failure to respond within this timeframe will result in the application being deemed incomplete and withdrawn. The application and any submitted documentation will not be returned. [If the applicant fails to respond within 21 calendar days of the notification, the application will be deemed incomplete and returned to the applicant.]

(f) - (n) (No change.)

§402.401. Temporary License.

(a) (No change.)

(b) General.

(1) - (3) (No change.)

(4) Voluntary surrender of regular license.

(A) An authorized organization that no longer holds a regular license to conduct bingo may conduct any remaining designated temporary occasions so long as the total number of occasions does not exceed twelve (12) per calendar year. If more than twelve (12) previously specified occasions remain, the licensed authorized organization must provide to the Commission written notification of no more than twelve (12) of the dates of the temporary licenses that will be utilized. This notification must be provided within ten days of surrender of the regular license. The Commission will automatically revoke all temporary licenses that have not been designated within ten days of surrender [in excess of the twelve (12) per year].

(B) (No change.)

(5) (No change.)

(c) - (d) (No change.)

(e) Non-regular license holder. A non-regular license holder that wishes to conduct a bingo occasion must file a complete application for a temporary license on a form prescribed by the Commission at least 30 calendar days prior to the bingo occasion.

(1) If an organization has never received a temporary license or 3 years have elapsed since the organization last held a temporary bingo occasion, the organization must submit an [a Texas] Application for Temporary Bingo Occasions for Non-Regular [Non-Licensed] Organization, FORMID 20 [- Section 2].

(2) Organizations who have held a temporary license occasion in the past three years may submit an [Texas] Application for a Temporary Bingo Occasions for Non-Regular [Non-Licensed] Organization, FORMID 19, [- Section 1] to apply for a temporary license.

(3) (No change.)

§402.402. Registry of Bingo Workers.

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

(1) - (4) (No change.)

(5) Completed Application--A registry application or renewal form prescribed by the Commission which is legible and lists at a minimum the applicant's complete legal name, address, social security number or registry number, date of birth, [race,] gender and signature.

(6) - (10) (No change.)

(b) - (s) (No change.)

§402.404. License Classes and Fees.

(a) Definitions.

(1) (No change.)

(2) [Regular] License Classes and Applicable Fee Amount:

(A) - (C) (No change.)

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

(f) [Regular] License Class Recalculation.

(1) - (7) (No change.)

(g) - (j) (No change.)

§402.411. License Renewal.

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

(c) The Commission may notify licensees regarding the expiration of their license(s) and the potential for renewal. Failure of the licensee to receive the renewal notice(s) provided [mailed] by the Commission is not a mitigating circumstance for untimely filing of a renewal application.

[(d) To be timely filed:]

[~~(1) the renewal application and payment, if applicable, of the estimated license fee must be received by the Commission no later than the license expiration date; or~~]

[~~(2) the renewal application's envelope postmarked date must clearly show a date that is no later than the license expiration date, unless the expiration date is a Saturday, Sunday, or legal holiday, in which event the application is due the next day which is not a Saturday, Sunday, or legal holiday; or~~]

[~~(3) an application bearing no legible postmark, postal meter date, or date of delivery to the common carrier shall be considered to have been sent seven calendar days before receipt by the Agency, or on the date of the document if the document date is less than seven days earlier than the date of receipt.~~]

(d) [~~(e)~~] Notwithstanding subsection (b) of this section, if a renewal application is not timely filed, a licensee may renew its [~~their~~] license by filing a complete application for renewal with the Commission and, if applicable, submitting the requisite license fee and late license renewal fee. The late license renewal fee is based on the estimated license fee for the renewal period. Penalty amounts are calculated as follows:
Figure: 16 TAC §402.411(d)
[~~Figure: 16 TAC §402.411(e)~~]

(e) [~~(f)~~] Any required late license renewal fee is due within 14 calendar days of the date of the written notification by the Commission of the amount due.

(f) [~~(g)~~] The Commission will not issue a temporary license to a licensed authorized organization that has not filed its renewal application.

(g) [~~(h)~~] A late license renewal fee is not refundable.

(h) [~~(i)~~] License renewal applications received more than 60 days after the license expiration date will be returned unprocessed by the Commission to the sender.

(i) [~~(j)~~] To be complete, an application for renewal must contain all information that is required to be provided in or with the initial license application, as well as any other information required by the Commission.

(1) - (2) (No change.)

(j) [~~(k)~~] Unless otherwise provided by law or rule, the general licensing provisions in §402.400 of this title (relating to General Licensing Provisions) shall govern the license renewal process, including the submission and review of the renewal application, as if the renewal application was an initial license application.

(k) [~~(l)~~] Except as authorized by the Charitable Bingo Operations Director, or his or her [~~their~~] designee, license renewal applications received by the Commission more than 60 days prior to the current license expiration date will be returned unprocessed by the Commission to the sender.

§402.443. Transfer of a Grandfathered Lessor's Commercial Lessor License.

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

(c) A change in the name or the ownership of a legal entity that holds a grandfathered license does not constitute a transfer of the license if the entity's Comptroller's Taxpayer Number remains the same.

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. BOOKS AND RECORDS

16 TAC §402.500, §402.502

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.500. General Records Requirements.

(a) - (d) (No change.)

(e) Bingo uses cash basis accounting, which records revenue and expenses when the cash related to those transactions is actually received or dispensed.

§402.502. Charitable Use of Net Proceeds Recordkeeping.

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

(c) Record Keeping:

(1) - (4) (No change.)

(5) A licensed authorized organization must maintain documentation for all charitable distributions made to individuals or other organizations. These [~~may, but are not required to~~] include:

(A) - (B) (No change.)

(6) A licensed authorized organization must maintain documentation for all charitable distributions used for its exempt purposes. Documentation [~~may, but is not required to~~] includes [~~include~~]:

(A) - (B) (No change.)

(7) - (11) (No change.)

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

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SUBCHAPTER F. PAYMENT OF TAXES, PRIZE FEES AND BONDS

16 TAC §§402.600 - 402.602

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.600. Bingo Reports and Payments.

(a) On or before the 25th of the month prior to the end of the calendar quarter, the Commission may provide reminder notifications to licensees regarding upcoming filing deadlines [~~will mail the "Texas Bingo Conductor's Quarterly Reports", "Texas Lessor Quarterly Reports", and "Manufacturer/Distributer Quarterly Reports and Supplements" to its licensees~~].

(b) Quarterly reports, supplements, and payments due to be submitted on a date occurring on a Saturday, Sunday, or legal holiday will be due the next business day. The report will be deemed filed in accordance with Rule §402.105 [~~when deposited with the United States Postal Service or private mail service, postage or delivery charges paid and the postmark or shipping date indicated on the envelope is the date of filing. For quarterly reports and supplements submitted electronically, the report will be deemed filed as of the date and time sent from the specified e-mail address~~].

(c) - (e) (No change.)

(f) Quarterly report for information relating to a manufacturer or distributor license.

(1) A manufacturer or [~~of~~] distributor shall file a report on a form prescribed by the Commission or in an electronic format prescribed by the Commission, reflecting each sale or lease of bingo equipment, and the total sales of cards, sheets, pads and instant bingo to a person or organization in this state or for use in this state.

(2) - (5) (No change.)

(g) - (m) (No change.)

§402.601. Interest on Delinquent Tax.

(a) (No change.)

(b) Interest on Refund or Credit.

(1) (No change.)

(2) A credit of $100.00 or less entered by a licensed authorized organization or lessor on its quarterly report does not accrue interest. The credit will be accessible for viewing in the Bingo Service Portal or through the agency's system for any inquiries regarding the current filing quarter [~~preprinted on the quarterly report reflecting the amount of the credit to be taken from the current quarter~~]. A credit taken by a licensed authorized organization or lessor on the quarterly report does not accrue interest.

(3) - (4) (No change.)

§402.602. [~~Waiver of Penalty.~~] Settlement of Prize Fees, Penalty and/or Interest.

[~~(a) The Charitable Bingo Operations Director, for good cause shown, may waive a penalty if a licensee holding a license to conduct bingo or license to lease bingo premises exercised reasonable diligence to comply with Occupations Code, §2001.504. The Charitable Bingo Operations Division will not consider a request for a penalty or interest waiver until the principal related to the specific request is paid in full. To be considered, a written request stating the reason(s) penalty should be waived must be sent to the Charitable Bingo Operations Division within 14 days of the date the quarterly report and prize fees were due.~~]

[~~(1) The Charitable Bingo Operations Division will inform the licensee in writing within three days of the Charitable Bingo Operations Division's decision regarding the penalty waiver request after considering:~~]

[~~(A) Whether the licensee is current in the filing of all reports;~~]

[~~(B) Whether the licensee is current in the payment of all prize fees due for the last eight consecutive quarters;~~]

[~~(C) Whether a penalty has been waived within the last eight consecutive quarters;~~]

[~~(D) Whether the licensee has a good record of timely filing and paying past returns; and~~]

[~~(E) Whether the licensee has taken the necessary steps to correct the problem for future reporting.~~]

[~~(2) If a licensee has had a penalty waived within the last eight consecutive quarters, the current request will be denied.~~]

[~~(b) If a prize fee is owed for an inactive account, the Charitable Bingo Operations Division will not consider a request for a penalty or interest waiver until the principal is paid in full. The Division will notify the inactive account that a prize fee is owed and provide the inactive account with any existing documents that support the delinquency determination. The Division may provide such notice and documentation to any officer, director, or business contact listed in the inactive account's most recent filing with the Commission.~~]

[~~(c)~~] Settlement of prize fees, penalty or interest on an inactive account. The Commission may settle a claim for prize fees, penalty, or interest if the total cost of collection, as determined by the Commission, would exceed the total amount due.

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. COMPLIANCE AND ENFORCEMENT

16 TAC §§402.702, 402.703, 402.706, 402.707

The amendments are proposed under Texas Occupations Code §2001.054, which authorizes the Commission to adopt rules to enforce and administer the Bingo Enabling Act, and Texas Government Code §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

This proposal is intended to implement Texas Occupations Code, Chapter 2001.

§402.702. Disqualifying Convictions.

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

(c) For criminal convictions that do not fall under the categories addressed in subsection (b) of this section, the Commission may determine an applicant to be ineligible for a new or renewal license or a registry listing based on a criminal conviction for:

(1) (No change.)

(2) An offense under [~~§3g,~~] Article 42A.054 of the Code of Criminal Procedure; or

(3) (No change.)

(d) - (l) (No change.)

§402.703. Audit Policy.

(a) (No change.)

(b) Audit Determination.

(1) (No change.)

(2) Those licensees who are most at risk of violating the Bingo Enabling Act or the Charitable Bingo Administrative Rules will be identified for audit based on risk factors established by the Commission. Risk factors shall [~~may~~] be based on, among other things, a licensee's gross receipts, gross rentals, bingo expenses, net proceeds, compliance history, and/or charitable distributions. An audit must commence by the fourth anniversary of the date a licensee is identified for audit.

(3) (No change.)

(c) - (g) (No change.)

§402.706. Schedule of Sanctions.

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

(c) Unless otherwise provided by this subchapter, the terms and conditions of a settlement agreement between the Commission and a person charged with violating the Bingo Enabling Act and/or the Charitable Bingo Administrative Rules will be based on the Schedule of Sanctions incorporated into this section.
Figure: 16 TAC §402.706(c)
[~~Figure: 16 TAC §402.706(c)~~]

(d) - (h) (No change.)

(i) If a person is charged with a repeat violation within 36 months (3 years) of a previous violation, then the sanction for a repeat violation will be imposed according to the Schedule of Sanctions for repeat violations. A repeat violation of a previous violation means that the violations in both instances are the same.

(j) - (l) (No change.)

§402.707. Expedited Administrative Penalty Guidelines.

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

(d) The NAVSA shall include the following information:

(1) - (3) (No change.)

(4) the dollar amount of the administrative penalty recommended by the director [~~Director~~] or his or her designee;

(5) - (9) (No change.)

(e) - (f) (No change.)

(g) If a person is charged with a repeat violation that may be expedited within 36 months (3 years) of the first violation, then the penalty for a repeat violation will be imposed according to the Expedited Administrative Penalty Chart for repeat violations.
Figure: 16 TAC §402.707(g)
[~~Figure: 16 TAC §402.707(g)~~]

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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General Counsel
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TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 4. RULES APPLYING TO ALL PUBLIC INSTITUTIONS OF HIGHER EDUCATION IN TEXAS

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §4.9

The Texas Higher Education Coordinating Board (Coordinating Board) proposes amendments to Texas Administrative Code, Title 19, Part 1, Chapter 4, Subchapter A, §4.9, relating to Limitations on the Number of Courses that May be Dropped Under Certain Circumstances by Undergraduate Students. Specifically, the proposed amendments include a re-organization of some subsections for clarity, and guidelines for institutions regarding statutory requirements for allowing a student to drop six or more courses. The proposed amendments also include a provision requiring an institution to maintain an appeals process where required by the Americans with Disabilities Act.

Elizabeth Mayer, Assistant Commissioner for Academic and Health Affairs, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rule. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Elizabeth Mayer, Assistant Commission for Academic and Health Affairs, has also determined that for each year of the first

five years the section is in effect, the public benefit anticipated as the result of adopting this rule is to provide procedures and guidelines for institutions relating to exceptions to the maximum of six course drops and to bring the statute into alignment with statutory requirements. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Elizabeth Mayer, Assistant Commissioner for Academic and Health Affairs, P.O. Box 12788, Austin, Texas 78711-2788, or via email at ahacomments@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The amendment is proposed under Texas Education Code, Section 51.907(e), which directs the Coordinating Board to adopt rules under which an institution shall permit a student to drop more than six courses.

The proposed amendment affects Texas Education Code, Section 51.907.

§4.9. Limitations on the Number of Courses that May be Dropped Under Certain Circumstances by Undergraduate Students.

(a) Beginning with the fall 2007 academic term, and applying to students who enroll in higher education for the first time during the fall 2007 academic term or any term subsequent to the fall 2007 term, an institution of higher education may not permit an undergraduate student a total of more than six dropped courses, including any course a transfer student has dropped at another institution of higher education, unless any of the conditions listed in subsection (b) of this section are met. If an institution adopts a policy allowing fewer than six dropped courses under Texas Education Code, §51.907(d), but a student at that institution meets the criteria in subsection (b) of this section, the institution shall allow that student to drop an additional course or courses.[:]

(b) An institution of higher education shall permit a student to drop more than six courses if the institution determines good cause exists. If one of the following situations has occurred, an institution shall consider it good cause for purposes of this chapter:

[(1) the institution has adopted a policy under which the maximum number of courses a student is permitted to drop is less than six; or]

(1) [(2)] a disaster declared by the governor results in cessation or limitation of in-person course attendance by students at the institution of a duration determined by the institution to significantly affect the student's ability to participate in course work with consideration of the length of time of the cessation or limitation of in-person course attendance, the type of courses, and the personal circumstances of students affected by the disaster; or

(2) [(3)] the student shows good cause for dropping more than that number, including [but not limited to] a showing of:

(A) a severe illness or other debilitating condition that affects the student's ability to satisfactorily complete the course;

(B) the student's responsibility for the care of a sick, injured, or needy person if the provision of that care affects the student's ability to satisfactorily complete the course;

(C) the death of a person who is considered to be a member of the student's family or who is otherwise considered to have a sufficiently close relationship to the student that the person's death is considered to be a showing of good cause;

(D) the active duty service as a member of the Texas National Guard or the armed forces of the United States of either the student or a person who is considered to be a member of the student's family or who is otherwise considered to have a sufficiently close relationship to the student that the person's active military service is considered to be a showing of good cause; or

[(E) the change of the student's work schedule that is beyond the control of the student, and that affects the student's ability to satisfactorily complete the course; or]

(E) [(F)] other good cause as determined by the institution of higher education.

[(4) the enrollment is for a student who qualifies for a seventh course enrollment, who:]

(3) An institution shall permit a student who meets the criteria in this paragraph but does not meet the criteria in paragraphs (1) or (2) of this subsection to drop one additional course in addition to the number typically permitted by the institution's policy. If the institution has not adopted a policy under Texas Education Code, §51.907(d), such a student shall be permitted to drop a seventh course if:

(A) the student has reenrolled at the institution following a break in enrollment from the institution or another institution of higher education covering at least the 24-month period preceding the first class day of the initial semester or other academic term of the student's reenrollment; and

(B) the student successfully completed at least fifty [50] semester credit hours of course work at an institution of higher education that have not been determined to be excess hours pursuant to [are not exempt from the limitation on formula funding set out in] §13.104(1) - (6) of this title (relating to Exemptions for Excess Hours) before that break in enrollment.

[(b) For purposes of this section, a "member of the student's family" is defined to be the student's spouse, child, grandchild, father, mother, brother, sister, grandmother, grandfather, aunt, uncle, nephew, niece, first cousin, step-parent, step-child, or step-sibling; a "person who is otherwise considered to have a sufficiently close relationship to the student" is defined to include any other relative within the third degree of consanguinity, plus close friends, including but not limited to roommates, housemates, classmates, or other persons identified by the student, for approval by the institution on a case-by-case basis.]

(c) For purposes of this section, a "member of the student's family" is defined to be the student's spouse, child, father, mother, brother, sister, step-parent, step-child, or step-sibling.

[(c) For purposes of this section, a "grade" is defined to be the indicator, usually a letter like A, B, C, D, or F, or P (for pass) assigned upon the student's completion of a course. A "grade" indicates either that the student has earned and will be awarded credit, if the student has completed the course requirements successfully; or that the student remained enrolled in the course until the completion of the term or semester but failed to provide satisfactory performance required to be awarded credit. A "grade" under this definition does not include symbols to indicate that the course has been left incomplete, whether those symbols indicate a negotiated temporary suspension of the end-of-term deadline for completion of the course requirements commonly designated as "incomplete" status, a dropped course under the conditions designated for this section, or a withdrawal from the institution.]

(d) For the purposes of this section, a "person who is otherwise considered to have a sufficiently close relationship to the student" may include any other relative within the second or third degree of consanguinity, close friends, roommates, or classmates.

(e) An institution shall determine on a case-by-case basis whether a student demonstrates good cause due to the death of a person outlined in subsection (d) of this section.

(f) [(d)] An institution of higher education may not count toward the number of courses permitted to be dropped a course that the student dropped:

(1) while enrolled in a baccalaureate degree program previously earned by the student; or

(2) a dual credit or dual enrollment course that a student dropped before graduating from high school.

(g) [(e)] Each institution of higher education shall adopt a policy [and procedure] for determining a showing of good cause as specified in subsection (b) [subsection (a)] of this section and shall provide a copy of the policy to the Coordinating Board.

(1) Each institution of higher education shall publish the policy adopted under this subsection in its catalogue and other print and Internet-based publications as appropriate for the timely notification of students.

(2) The policy shall include a defined appeals process that complies with the Americans with Disabilities Act, 42 U.S.C. § 12101, for a student requesting to drop additional classes pursuant to the exception provided in subsection (b)(2)(A) of this section. An institution may institute an appeals process for students requesting an exemption under any of the other subsections.

[(f) Each institution of higher education shall publish the policy adopted under this section in its catalogue and other print and Internet-based publications as appropriate for the timely notification of students.]

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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Nichole Bunker-Henderson
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CHAPTER 9. PROGRAM DEVELOPMENT IN PUBLIC TWO-YEAR COLLEGES
SUBCHAPTER E. CERTIFICATE AND ASSOCIATE DEGREE PROGRAMS

19 TAC §§9.91 - 9.96

The Texas Higher Education Coordinating Board (Coordinating Board) proposes the repeal of Texas Administrative Code, Title 19, Part 1, Chapter 9, Subchapter E, §§9.91 - 9.96, concerning Certificate and Associate Degree Programs. Specifically, this repeal will remove sections superseded by program approval rules adopted by the Coordinating Board in July 2024 which are now in Chapter 2 of this title.

The Coordinating Board is required to review and approve requests for all new certificate and degree program requests offered in the state of Texas and has the authority to adopt, amend, and repeal rules for that purpose.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be clarifying administrative code by removing sections from the Texas Administrative Code that are superseded by rules approved by the Texas Higher Education Coordinating Board in July 2024. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Elizabeth Mayer, Assistant Commissioner for Academic and Health Affairs, P.O. Box 12788, Austin, Texas 78711-2788, or via email

at AHAcomments@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The repeal is proposed under Texas Education Code, Section 61.0512, which provides the Coordinating Board with the authority to approve new degree and certificate programs.

The proposed repeal affects Texas Education Code, Section 61.0512.

§9.91. Purpose.

§9.92. Authority.

§9.93. Presentation of Requests and Steps for Implementation of New Degree and Certificate Programs in Career Technical/Workforce Education.

§9.94. Action and Order of the Board.

§9.95. Reporting to the Board.

§9.96. Disapproval of Programs; Noncompliance.

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 October 31, 2024.

TRD-202405203
Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 427-6182

SUBCHAPTER F. WORKFORCE CONTINUING EDUCATION COURSES

19 TAC §§9.111 - 9.118

The Texas Higher Education Coordinating Board (Coordinating Board) proposes the repeal of Texas Administrative Code, Title 19, Part 1, Chapter 9, Subchapter F, §§9.111 - 9.118, concerning Workforce Continuing Education Courses. Specifically, this repeal will remove sections superseded by program approval rules adopted by the Coordinating Board in July 2024 which are now in Chapter 2 of this title.

The Coordinating Board is required to review and approve requests for workforce continuing education courses offered in the state of Texas and has the authority to adopt, amend, and repeal rules for that purpose.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be clarifying administrative code by removing sections from the Texas Administrative Code that are superseded by rules approved by the Texas Higher Education Coordinating Board in July 2024. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Elizabeth Mayer, Assistant Commissioner for Academic and Health Affairs, P.O. Box 12788, Austin, Texas 78711-2788, or via email at AHAcomments@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The repeal is proposed under Texas Education Code, Section 130.001(b)(3), which provides the Coordinating Board with the authority to adopt standards for the operation of a college, and Section 61.0512, which provides the Coordinating Board with the authority to approve new degree and certificate programs.

The proposed repeal affects Texas Education Code, Sections 130.001(b)(3) and 61.0512.

§9.111. Purpose.

§9.112. Authority.

§9.113. Definitions.

§9.114. General Provisions.

§9.115. Application and Approval Procedures for Workforce Continuing Education Courses.

§9.116. Waiver of Tuition and Fees.

§9.117. Funding.

§9.118. Reporting to the Board.

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

Filed with the Office of the Secretary of State on October 31, 2024.

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Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 427-6182

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SUBCHAPTER I. DISTANCE EDUCATION

19 TAC §§9.161 - 9.163

The Texas Higher Education Coordinating Board (Coordinating Board) proposes the repeal of Texas Administrative Code, Title 19, Part 1, Chapter 9, Subchapter I, §§9.161 - 9.163, regarding Distance Education. Specifically, this repeal will remove sections superseded by program approval rules adopted by the Coordinating Board in July 2024 which are now in Chapter 2 of this title.

The Coordinating Board is required to review and approve requests for all Distance Education degree program requests offered in the state of Texas and has the authority to adopt, amend, and repeal rules for that purpose.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Elizabeth Mayer, Assistant Commissioner of Academic and Health Affairs, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be clarifying administrative code by removing sections from the Texas Administrative Code that are superseded by rules approved by the Texas Higher Education Coordinating Board in July 2024. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

(2) implementation of the rules will not require the creation or elimination of employee positions;

(3) implementation of the rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the rules will not require an increase or decrease in fees paid to the agency;

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Elizabeth Mayer, Assistant Commissioner for Academic and Health Affairs, P.O. Box 12788, Austin, Texas 78711-2788, or via email at AHAcomments@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

The repeal is proposed under Texas Education Code, Section 61.0512(g), which provides the Coordinating Board with the authority to approve distance education offered for credit.

The proposed repeal affects Texas Education Code, Section 61.0512(g).

§9.161. Purpose.

§9.162. Authority.

§9.163. Courses and Programs Offered through Distance Education.

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 October 31, 2024.

TRD-202405207
Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 427-6182

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TITLE 22. EXAMINING BOARDS

PART 24. TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS

CHAPTER 571. LICENSING

SUBCHAPTER A. GENERAL

22 TAC §571.7

The Texas Department of Licensing and Regulation (Department), on behalf of the Texas Board of Veterinary Medical Examiners (TBVME), proposes an amendment to the existing rules at 22 Texas Administrative Code (TAC), Chapter 571, Subchapter A, §571.7, regarding the Licensing duties. The proposed change is referred to as the "proposed rule."

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 22 TAC, Chapter 571, implement Texas Occupations Code, Chapter 801, Veterinary Licensing Act.

The proposed rule extends the time period in which an applicant for a veterinary license who has not yet graduated from veterinary medical school may obtain a document confirming their expected graduation date in order to apply for the State Board Examination (SBE) from 60 days to 120 days. This proposed rule change was suggested by a major stakeholder, Texas Tech University School of Veterinary Medicine (Texas Tech), to align with their schedule for students in their final year of school. Texas Tech fourth-year students spend most of their year at externships throughout the state but return to the campus in February of the year they graduate. Texas Tech, in an attempt to limit costs to their students, wants to proctor a SBE for their graduating students in February while the students are all on campus. By allowing the students to obtain a document confirming their expected graduation date 120 days prior to graduation, this allows Texas Tech students to take the SBE on campus in February prior to their graduation. This change will also benefit all graduating veterinary students, both in-state and out-of-state, in that it allows them to take the SBE sooner.

Advisory Board Recommendations

The Texas Board of Veterinary Medical Examiners (TBVME) proposed the rule at its meeting on July 16, 2024, and recommended that the proposed rule be published in the *Texas Register* for public comment.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §571.7(f)(1) to extend the time period in which an applicant for a veterinary license who has not yet graduated from veterinary medical school may obtain a document confirming their expected graduation date in order to apply for the State Board Examination (SBE) from 60 days to 120 days.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Tony Couvillon, Policy Research and Budget Analyst, has determined that for each year of the first five years the proposed rule is in effect, there are no estimated additional costs or reductions in costs to state or local government as a result of enforcing or administering the proposed rule. The activities required to implement the proposed rule change, if any, are program administration tasks that are routine in nature, such as modifying or revising publications and/or website information. The proposed rule will not require an increase in personnel or resources and therefore will not result in an increase in costs to the State.

Mr. Couvillon has determined that for each year of the first five years the proposed rule is in effect, there is no estimated increase or loss in revenue to the state or local government as a result of enforcing or administering the proposed rule. The proposed rule does not create a revenue loss, as it does not eliminate or decrease any fees assessed by the program.

Mr. Couvillon has determined that for each year of the first five years the proposed rule is in effect, enforcing or administering the proposed rule does not have foreseeable implications relating to costs or revenues of state governments.

Mr. Couvillon has also determined that for each year of the first five years the proposed rule is in effect, enforcing or administering the proposed rule does not have foreseeable implications relating to costs or revenues of local governments. The proposed rule has no impact on local government costs because local governments are not responsible for the regulation of veterinarians under Texas Occupations Code 801 or the administrative rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

Because Mr. Couvillon has determined that the proposed rule will not affect a local economy, the agency is not required to prepare a local employment impact statement under Texas Government Code §2001.022. The change made by the proposed rule is not anticipated to increase or decrease the number of persons who are licensed or who choose to become licensed as veterinarians, nor is it anticipated to affect the need for veterinarians. Therefore, the proposed rule will have no effect on local employment.

PUBLIC BENEFITS

Mr. Couvillon has determined that for each year of the first five-year period the proposed rule is in effect, the public benefit will be an increase in the lead time in which an applicant for a veterinary license may request documentation that will allow the applicant to begin the process of meeting the conditions to apply for the SBE prior to graduation. This increase in time will allow students more time and flexibility in organizing the necessary scheduling prior to graduation.

PROBABLE ECONOMIC COSTS TO PERSONS REQUIRED TO COMPLY WITH PROPOSAL

Mr. Couvillon has determined that for each year of the first five-year period the proposed rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule. The proposed rule imposes no costs for any veterinary student, licensee, business, or member of the public. The change merely allows an applicant for the SBE to begin the process of obtaining the necessary documentation 120 days prior to graduation rather than the current 60 days.

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

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities as a result of the proposed rule. The proposed rule will have no adverse economic effect on any small or micro-businesses because the proposed rule will impart no additional costs on any business. The proposed rule will have no anticipated adverse economic effect on rural communities, because the proposed rule will not decrease the availability of veterinary services in rural communities, nor will the rule increase the cost of veterinary services in rural communities. Because the agency has determined that the proposed rule 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.

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

The proposed rule does not have a fiscal note that imposes a cost on regulated persons, including another state agency, a special district, or a local government. Therefore, the agency is not required to take any further action under Texas Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Texas Government Code §2001.0221, the agency provides the following Government Growth Impact Statement for the proposed rule. For each year of the first five years the proposed rule will be in effect, the agency has determined the following:

1. The proposed rule does not create or eliminate a government program.

2. Implementation of the proposed rule does not require the creation of new employee positions or the elimination of existing employee positions.

3. Implementation of the proposed rule does not require an increase or decrease in future legislative appropriations to the agency.

4. The proposed rule does not require an increase or decrease in fees paid to the agency.

5. The proposed rule does not create a new regulation.

6. The proposed rule does not expand, limit, or repeal an existing regulation.

7. The proposed rule does not increase or decrease the number of individuals subject to the rules' applicability.

8. The proposed rule does not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

The Department 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 his or her 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.

PUBLIC COMMENTS

Comments on the proposed rules may be submitted by email to *TBVME.Comments@tdlr.texas.gov*; by facsimile to (512) 475-3032; or by mail to Monica NuÃ±ez, Legal Assistant, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711. The deadline for comments is 30 days after publication in the *Texas Register.*

STATUTORY AUTHORITY

The proposed rules are proposed under the authority of Texas Occupations Code, Chapters 51 and 801, which authorizes the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 801. No other statutes, articles, or codes are affected by the proposed rules.

§571.7. Veterinary Licensing Eligibility.

(a) - (e) (No change.)

(f) Eligibility Prior to Graduation. An applicant for a veterinary license who has not graduated from veterinary medical school may apply for the SBE provided the following conditions have been met:

(1) An applicant must be enrolled in an approved and accredited veterinary medical school or college as defined in §571.1(10) of this title and must obtain a document from the dean of the school or college from which the applicant expects to graduate certifying that the applicant is within 120 [~~60~~] days of completion of a veterinary college program and is expected to graduate.

(2) - (3) (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.

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405234
Doug Jennings
General Counsel
Texas Board of Veterinary Medical Examiners
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 475-4879

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 40. STOCK MEDICATION IN SCHOOLS AND OTHER ENTITIES

SUBCHAPTER D. MAINTENANCE AND ADMINISTRATION OF [~~ASTHMA~~] MEDICATION FOR RESPIRATORY DISTRESS

25 TAC §§40.41 - 40.49

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), proposes amendments to 25 Texas Administrative Code (TAC) Chapter 40, Subchapter D, §§40.41 - 40.49, concerning Maintenance and Administration of Asthma Medication.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement Senate Bill (S.B.) 294, 88th Legislature, Regular Session, 2023, which amends Texas Education Code (TEC) Chapter 38, Subchapter E by replacing references to asthma medication with medication for respiratory distress.

TEC §38.208 requires the Executive Commissioner of the Health and Human Services Commission, in consultation with the commissioner of Texas Education Agency (TEA) and the Stock Epinephrine Advisory Committee (SEAC), to adopt rules regarding the maintenance, administration, and disposal of medication for respiratory distress at a school campus subject to a policy adopted and implemented by each school district, open-enrollment charter school, and private school.

TEC §38.208 also requires the rules to establish the process for checking inventory, the amount of training for school personnel and volunteers, and the types of medication that may be administered.

TEC §38.2091 requires schools to report information on the administration of medication for respiratory distress to the commissioner of DSHS.

SECTION-BY-SECTION SUMMARY

The proposed amendments replace references to "asthma medication" with "medication for respiratory distress" for consistency throughout the subchapter. This proposal renames Subchapter D, as Maintenance and Administration of Medication for Respiratory Distress.

The proposed amendment to §40.41 replaces wording, edits language for clarity, and adds an acronym for Texas Education Code.

The proposed amendment to §40.42 provides revised and new definitions, replaces an acronym with the spelled out reference, and renumbers the subsection.

The proposed amendment to §40.43 replaces wording and edits language for clarity.

The proposed amendment to §40.44 adds policy requirements for school personnel and volunteers authorized and trained to administer medications, the treatment of multiple students, medication inventory, referral process for student to primary healthcare provider, process for providing information to assist in se-

lecting a primary healthcare provider for the student, and renumbers the subsection.

The proposed amendment to §40.45 replaces wording, edits language for clarity, adds an acronym for Texas Education Code, and adds policy requirements for storage of medication.

The proposed amendment to §40.46 replaces policy requirements for training nurses by expanding training to school personnel or school volunteers in the administration of unassigned medication for respiratory distress, replaces wording, edits for language clarity, adds policy requirements for hands-on training, and informing of the purpose and use of asthma action plans.

The proposed amendment to §40.47 replaces wording and edits for language clarity, replaces policy requirements of nurse administering the medication for respiratory distress to school personnel or school volunteer, replaces reporting to a school administrator with reporting to the school district, charter holder or governing body of a private school, replaces a spelled out reference to an acronym, and renumbers the subsection.

The proposed amendment to §40.48 replaces wording and edits for language clarity and replaces a spelled out reference to an acronym.

The proposed amendment to §40.49 replaces a spelled out reference to an acronym.

FISCAL NOTE

Christy Havel Burton, 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

DSHS 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 DSHS 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 DSHS;

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

(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

Christy Havel Burton determined there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules do not apply to small or micro-businesses, 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 are necessary to protect the health, safety, and welfare of the residents of Texas and to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Dr. Manda Hall, Associate Commissioner, Community Health Improvement Division, has determined that for each year of the first five years the rules are in effect, the public will benefit from safer public, charter, and private schools authorized to administer respiratory distress medicine to a person reasonably believed to be experiencing respiratory distress.

Christy Havel Burton has determined that for the first five years the rules are in effect, there are no probable economic costs to persons required to comply with the rule. This is because schools are not required to adopt a policy on maintaining, administering, and disposing of medications for respiratory distress, and are not required to stock medication.

TAKINGS IMPACT ASSESSMENT

DSHS 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 West 51st Street, Austin, Texas 78751; or emailed to SchoolHealth@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) 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 24R030" in the subject line.

STATUTORY AUTHORITY

The proposal is required to comply with TEC Chapter 38 Subchapter E. The proposed amendments are also authorized by Texas Government Code §531.0055 and Texas Health and Safety Code §1001.075, which authorize the Executive Commissioner of HHS to adopt rules necessary 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 amendments implement TEC Chapter 38, Texas Government Code §531.0055, and Texas Health and Safety Code Chapter 1001.

§40.41 Purpose.

The purpose of this subchapter is to establish minimum standards for administering, maintaining, and disposing of unassigned [~~asthma~~] medication for respiratory distress in school districts, open-enrollment charter schools, or [~~and~~] private schools [~~that~~] voluntarily adopting [~~adopt~~] unassigned [~~asthma~~] medication for respiratory distress poli-

cies. These standards are implemented under Texas Education Code (TEC) Chapter 38, Subchapter E.

§40.42 Definitions.

The following terms and phrases, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.[:]

(1) Authorized healthcare provider--A physician, as defined in TEC [Texas Education Code,] §38.201, or a person [who has been] delegated prescriptive authority by a physician under Texas Occupations Code Chapter 157.

(2) Campus--A geographic unit of a school district, open-enrollment charter school, or private school that:

(A) has an assigned administrator;

(B) has enrolled students who are counted for average daily attendance;

(C) has assigned instructional staff;

(D) provides instructional services to students;

(E) has one or more grades in the range from early childhood education through grade 12 or is ungraded; and

(F) is subject to Texas laws.

(3) Open-enrollment charter school--As defined in TEC §38.151.

(4) Private school--As defined in TEC §38.201.

(5) Regular school hours--At least 30 minutes before the first bell to 30 minutes after the last bell of the school day.

(6) School district--Independent school districts established under TEC Chapter 11, Subchapters A - F; and open-enrollment charter schools established under TEC Chapter 12, Subchapter D.

(7) [(3)] School nurse--Registered nurse, as defined in 19 Texas Administrative Code (TAC) §153.1022 (relating to Minimum Salary Schedule for Certain Professional Staff) [19 TAC §153.1022 (relating to Minimum Salary Schedule for Certain Professional Staff), authorized to administer asthma medication], or licensed vocational nurse working under supervision as described in Texas Occupations Code §301.353.

(8) School personnel--As defined in TEC §38.201.

(9) School-sponsored event--A school-sponsored or school-related activity occurring on or off school property.

(10) School volunteer--As defined in TEC §22.053.

(11) TEC--Texas Education Code.

(12) [(4)] Unassigned [asthma] medication for respiratory distress--Albuterol, levalbuterol, or another medication based on the best available medical evidence for the treatment of respiratory distress that is:

(A) [A fast acting bronchodilator] delivered by metered-dose [metered dose] inhaler (MDI) with a spacer (valved holding chamber) [single use spacer] or by a nebulizer as a rescue medication;[,]

(B) prescribed by an authorized healthcare provider in the name of the school district, open-enrollment charter school, or private school;[,]

(C) issued with a non-patient-specific standing delegation order for the administration of a [an asthma] medication for respiratory distress;[,] and

(D) issued by an authorized healthcare provider.

§40.43 Applicability.

The rules of this [This] subchapter apply [applies] to any school district, open-enrollment charter school, or private school [that] voluntarily choosing to adopt [adopts] and implement [implements] a written policy regarding the maintenance, administration, and disposal of unassigned [asthma] medication for respiratory distress at [on] each campus.

§40.44 Voluntary Unassigned [Asthma] Medication for Respiratory Distress Policies.

(a) A school district, open-enrollment charter school, or private school may voluntarily adopt and implement a written policy regarding the maintenance, administration, and disposal of unassigned [asthma] medication for respiratory distress at each campus.

(1) If a written policy is adopted under this subchapter, the:

(A) unassigned [asthma] medication for respiratory distress policy must comply with TEC [Texas Education Code] §38.208;[.]

(B) campus must have at least one school personnel or school volunteer authorized and trained to administer unassigned medication for respiratory distress present during regular school hours; and

(C) school personnel or school volunteer may not be subject to any penalty or disciplinary action for refusing to administer or receive training to administer unassigned medication for respiratory distress, as applicable.

(2) Subject to the availability of funding, a school district, open-enrollment charter school, or private school choosing to voluntarily adopt [that adopts] such a policy must allow for treatment of multiple students and secure or obtain at least: [the suggested minimum dosage of unassigned asthma medication.]

(A) one MDI with appropriate spacers (valved holding chambers) to accommodate the developmental needs of the student population, or

(B) at least five vials of nebulizer solution with appropriate nebulizer-required equipment to accommodate the developmental needs of the student population.

(b) In the development of an unassigned [asthma] medication for respiratory distress policy, a school district, open-enrollment charter school, or private school may consider performing a review to include:

(1) consultation with school nurses, the local school health advisory committee, local healthcare providers, or any department or organization involved with student well-being;

(2) campus geography; and

(3) student population size.

(c) If a school district, open-enrollment charter school, or private school voluntarily adopts an unassigned [asthma] medication for respiratory distress policy, the policy must include:

[(1) a process to obtain written authorization from a parent or guardian of the student that the student has been diagnosed as having asthma and stating that the school nurse may administer unassigned asthma medication to the student;]

(1) [(2)] the [a] designated campus administrator to coordinate and manage policy implementation, which [that] includes:

(A) conducting [whether to conduct] a review at the campus to determine the need for additional doses;

(B) training [of] school personnel and school volunteers [nurses];

(C) acquiring or purchasing, maintaining, storing, and using unassigned [asthma] medication for respiratory distress, subject to available campus funding; and

(D) disposing of expired unassigned [asthma] medication for respiratory distress;

(2) [(3)] a list of trained and authorized school personnel and school volunteers available [school nurses who will be assigned] to administer unassigned [asthma] medication for respiratory distress;

(3) [(4)] the locations of unassigned [asthma] medication for respiratory distress in compliance with TEC §38.208;

(4) [(5)] the procedures for notifying a parent, prescribing authorized healthcare provider, and the student's primary healthcare provider when unassigned [asthma] medication for respiratory distress is administered; [and]

(5) [(6)] a plan to check inventory of unassigned medication for respiratory distress for expiration at least twice during the school year, to replace, as soon as reasonably possible, and to document the findings; [any unassigned asthma medication that is used or close to expiration.]

(6) a referral process to the student's primary healthcare provider if the student's parent or guardian has not notified the school the student has been diagnosed with asthma, referral must include:

(A) symptoms of respiratory distress observed;

(B) name and dosage of the unassigned medication for respiratory distress administered to the student;

(C) patient care instructions given to the student; and

(D) information about the purpose and use of an asthma action plan and medical authorization for schools, including a blank copy of the plan and authorization the provider completes and returns to the school; and

(7) the process for providing information to assist the parent or guardian in selecting a primary healthcare provider for the student if the student received unassigned medication for respiratory distress and does not have a primary healthcare provider or the parent or guardian of the student has not engaged a primary healthcare provider for the student.

(d) An adopted unassigned [asthma] medication for respiratory distress policy must be publicly available.

§40.45 Prescription, Administration, and Disposal of Unassigned [Asthma] Medications for Respiratory Distress.

(a) Once a school district, open-enrollment charter school, or private school voluntarily adopts an unassigned [asthma] medication for respiratory distress policy, any [a] campus that implements an unassigned [asthma] medication for respiratory distress policy must stock unassigned [asthma] medication for respiratory distress, subject to available funding, as defined by §40.44 of this subchapter (relating to Voluntary Unassigned [Asthma] Medication for Respiratory Distress Policies).

(b) A campus must obtain a prescription from an authorized healthcare provider [each year] to stock, possess, and maintain [at least two doses of] unassigned [asthma] medication for respiratory distress at [on] each campus as described in TEC [Texas Education Code] §38.208 and any equipment necessary to administer the medication.

(1) The campus must renew this prescription or obtain a new prescription annually.

(2) In addition to the minimum number of doses as defined by §40.44 of this subchapter, the [The] number of additional doses may be determined by an individual campus review led by an authorized healthcare provider.

(c) An authorized healthcare provider prescribing [who prescribes] unassigned [asthma] medication for respiratory distress under subsection (b) of this section must provide the campus with a standing order for the administration of unassigned [asthma] medication for respiratory distress to a person experiencing respiratory distress. [who:]

[(1) is reasonably believed to be experiencing a symptom of asthma; and]

[(2) has provided written notification and permission as required by the unassigned asthma medication policy.]

(d) The unassigned [asthma] medication for respiratory distress must be stored in accordance with the manufacturer's guidelines and local policy of the school district, open-enrollment charter school, or private school. The location of medication for respiratory distress at each campus must be secure and easily accessible to authorized school personnel and school volunteers.

(e) Expired unassigned [asthma] medication for respiratory distress and other used or expired supplies must be disposed of in accordance with the manufacturer's guidelines and local policy of the school district, open-enrollment charter school, or private school.

§40.46 Training.

(a) A school district, open-enrollment charter school, or private school that chooses to adopt a written unassigned [asthma] medication for respiratory distress policy[, or a campus that is subject to this subchapter,] is responsible for training school personnel or school volunteers in the administration of unassigned medication for respiratory distress. Each authorized school personnel or school volunteer must receive initial training and an annual refresher training. The training must [nurses about]:

(1) include information on the adopted unassigned [asthma] medication for respiratory distress policy;

(2) cover the authorized healthcare provider's standing order;

(3) include processes to follow-up with the prescribing authorized healthcare provider and the student's primary healthcare provider; [and]

(4) provide information on the report required after administering [an] unassigned [asthma] medication for respiratory distress under §40.47 of this subchapter (relating to Report on Administering Unassigned [Asthma] Medication for Respiratory Distress);[.]

(5) meet the requirements found in TEC §38.210;

(6) incorporate hands-on training with unassigned medication for respiratory distress; and

(7) inform school personnel or school volunteers of the purpose and use of asthma action plans.

(b) Each campus must maintain training records and must make available upon request a list of school personnel and school volunteers [nurses] trained and authorized to administer [the] unassigned

[asthma] medication for respiratory distress at [on] the campus or at a school-sponsored event.

§40.47 Report on Administering Unassigned [Asthma] Medication for Respiratory Distress.

(a) Records relating to implementing and administering the school district, open-enrollment charter school, or private school's unassigned [asthma] medication for respiratory distress policy must be retained per the campus record retention schedule.

(b) The report required under this subsection must comply with TEC §38.2091.

(c) [(b)] The campus must submit a report no later than the 10th business day after the date a school personnel or school volunteer administered [nurse administers asthma] medication for respiratory distress in accordance with the unassigned [asthma] medication for respiratory distress policy adopted under this subchapter. The report must be included in the student's permanent record, if applicable, and must be submitted to the individuals and entities identified in TEC §38.2091:

(1) the school district, the charter holder if the school is an open-enrollment charter school, or the governing body of the school if the school is a private school;

(2) the physician or other person [school administrator,] prescribing the medication for respiratory distress; [authorized healthcare provider, the student's primary healthcare provider,] and

(3) [to] the Department of State Health Services (DSHS) commissioner [Commissioner].

(d) [(c)] Notifications to the DSHS commissioner [Commissioner] must be submitted on the designated electronic form available on the DSHS [DSHS's] School Health Program website found at dshs.texas.gov.

§40.48 Notice to Parents Regarding Unassigned [Asthma] Medication for Respiratory Distress Policies in Schools.

(a) If a school district, open-enrollment charter school, or private school implements an unassigned [asthma] medication for respiratory distress policy under this subchapter, the campus must [shall] provide written or electronic notice to a parent or guardian of each student in accordance with TEC [Texas Education Code] §38.212.

(b) If a school district, open-enrollment charter school, or private school changes or discontinues the unassigned [asthma] medication for respiratory distress policy under this subchapter, the campus must provide written or electronic notice detailing the change or discontinuation of the policy [must be provided] to a parent or guardian of each student within 15 calendar days after the change or discontinuation.

§40.49 Immunity from Liability.

A person who in good faith takes, or fails to take, any action under this subchapter[,] or TEC [Texas Education Code] Chapter 38, Subchapter E[,] is immune from civil or criminal liability or disciplinary action resulting from that action or a failure to act in accordance with TEC [Texas Education Code] §38.215(a).

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 October 30, 2024.

TRD-202405176
Cynthia Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 413-9089

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 16. COMPTROLLER GRANT PROGRAMS

SUBCHAPTER D. RURAL LAW ENFORCEMENT SALARY ASSISTANCE PROGRAM

34 TAC §§16.300, 16.303 - 16.305

The Comptroller of Public Accounts proposes amendments to §16.300, concerning definitions, §16.303, concerning awards; grant agreement, §16.304, concerning authorized uses of grant funds; limitations, and §16.305, concerning reporting and compliance.

The legislation enacted within the last four years that provides the statutory authority for these sections is Senate Bill 22, 88th Legislature, R.S., 2023.

The amendments to §16.300 modify the current definition of "county jailer" to simplify the term to "jailer" and clarify a permanent or temporary county jailer license is acceptable, by deleting the definition of "county jailer" in paragraph (2) and adding the definition of "jailer" in new paragraph (9). The amendments add a definition for "investigator" in new paragraph (8). The amendments also add to the definition of "safety equipment" in paragraph (13) that software is not included in the term unless it is purchased in connection with the purchase of tangible safety equipment and is necessary for that safety equipment to be functional.

The amendments to §16.303 modify subsection (d) to further explain that a legal obligation to expend funds requires an effective, binding contract. The amendments add new subsection (f), which clarifies who must electronically sign a grant agreement. The amendments also add new subsection (g) clarifying a qualified county may receive grants for their sheriff's office, constable's office, and prosecutor's office, including a prosecutor's office receiving more than one grant.

The amendments to §16.304 amend subsection (a) to clarify the minimum annual salary requirement applies to vacant positions upon hiring as described in this subsection and update the citations and grammar. The amendments delete duplicate language in subsection (a)(1) relating to the definitions of "deputy sheriff" and "jailer." The amendments relocate the language previously in subsection (d) to subsection (i) and add new language to subsection (d) to clarify impermissible uses of grant funds. The amendments make non-substantive changes to subsection (f). The amendments add new subsection (i), which describes the authorized uses of grant funds and limitations on uses of

grant funds with new examples. The amendments add new subsection (j), which describes the authorized uses of grant funds and limitations specific to additional employees hired with grant funds, and includes examples. The amendments add new subsection (k) to clarify when vehicle leases are considered purchases under subsection (a)(2)(C).

The amendments to §16.305 amend subsection (c) to provide that the comptroller may require a grant recipient to cure, to the satisfaction of the comptroller, a failure to comply with the requirements of subsection (b). The amendments add new subsection (d) to clarify the person who must electronically provide information and sign and certify the compliance report.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed amended rules are in effect, the rules: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed amended rules would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed amended rules would benefit the public by improving the clarity and implementation of the section. There would be no significant anticipated economic cost to the public. The proposed amended rules would have no fiscal impact on small businesses or rural communities.

Comments on the proposal may be submitted to Russell Gallahan, Manager, Local Government and Transparency, Comptroller of Public Accounts, P.O. Box 13186, Austin, Texas 78701-3186 or to the email address: SB22.Grants@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.*

These amendments are proposed under Local Government Code, §§130.911, 130.912 and 130.913, which authorize the comptroller to adopt rules to efficiently and effectively administer a grant program to provide financial assistance to qualified sheriff's offices, constable's offices, and prosecutor's offices in rural counties.

The amendments implement Local Government Code, §§130.911, 130.912 and 130.913.

§16.300. Definitions.

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

(1) Applicant--For an entity that applies for a grant under Local Government Code, §130.911 or §130.912, a qualified county, or, for an entity that applies for a grant under Local Government Code, §130.913, a qualified prosecutor's office.

[~~(2) County jailer--A person employed by the county sheriff as a licensed county jailer, under the provisions and requirements of Local Government Code, §85.005 and Occupations Code, §1701.301 whose duties include the safekeeping of prisoners and the security of a jail operated by the county.~~]

(2) [~~(3)~~] County sheriff--A person elected or appointed as the county sheriff and who performs the duties of the office after complying with Local Government Code, §85.001.

(3) [~~(4)~~] Deputy sheriff--A person appointed as deputy sheriff pursuant to Local Government Code, §85.003 who performs motor vehicle stops in the routine performance of their duties.

(4) [~~(5)~~] Fiscal year--The twelve consecutive calendar months during which an applicant tracks its finances for budget and accounting purposes.

(5) [~~(6)~~] Grant--A grant awarded under this subchapter that is a rural sheriff's office salary assistance grant under Local Government Code, §130.911, a rural constable's office salary assistance grant under Local Government Code, §130.912, or a rural prosecutor's office salary assistance grant under Local Government Code, §130.913.

(6) [~~(7)~~] Grant agreement--An agreement between the comptroller and a grant recipient that governs the terms of a grant.

(7) [~~(8)~~] Grant recipient--A qualified county or a qualified prosecutor's office that receives a grant under this subchapter.

(8) Investigator--A person employed by and appointed by the prosecutor's office as an investigator under Government Code, §41.102 and §41.109, and who is licensed under Occupations Code, §1701.301.

(9) Jailer--A person employed by the county sheriff as a jailer under Local Government Code, §85.005, who is licensed with a permanent or temporary county jailer license issued under Occupations Code, §1701.301 and §1701.307, or Government Code, §511.00905, and whose duties include the safekeeping of prisoners and the security of a jail operated by the county.

(10) [~~(9)~~] Population--The population shown by the most recent federal decennial census.

(11) [~~(10)~~] Qualified constable--A constable who meets the following standards:

(A) is elected to, and currently holds, an office created on or before January 1, 2023;

(B) performs motor vehicle stops in the routine performance of their duties for the majority of their time on duty; and

(C) meets all eligibility requirements to serve under Local Government Code, §86.0021, and Code of Criminal Procedure, article 2.12(2).

(12) [~~(11)~~] Qualified county--A county with a population of 300,000 or less.

(13) [~~(12)~~] Qualified prosecutor's office--An office of a district attorney, criminal district attorney, or county attorney with criminal prosecution duties whose jurisdiction has a population of 300,000 or less.

(14) [~~(13)~~] Safety equipment--Any tangible equipment used by a sheriff's office that is necessary to protect the health and physical safety of a county sheriff or deputy sheriff or county jailer while performing their duties, and may include radio equipment or in-car camera systems added to previously owned vehicles, ballistic helmets, ballistic plates, ballistic shields, entry tools, body armor, medical gear & masks, outer carriers, pepper spray, plate carriers, personal alarm, riot batons, riot helmets, riot shields, body cameras, and miscellaneous safety gear which consists of door jams, disposable cuffs and knee pads. The term does not include software unless it is purchased in connection with the purchase of tangible safety equipment and is necessary for that safety equipment to be functional.

(15) [~~(14)~~] Victim Assistance Coordinator--The person designated to serve as victim assistance coordinator under Code of Criminal Procedure, article 56A.201, by a district attorney, criminal district attorney, or county attorney who prosecutes criminal cases and who is responsible for the duties listed in Code of Criminal Procedure, article 56A.202.

(16) [~~(15)~~] Vehicle--A law enforcement vehicle used by a sheriff's office for transportation while performing duties of the office such as patrols, responses to calls for service, and transport of persons in custody, and includes equipment affixed to the vehicle for law enforcement purposes.

§16.303. Awards; Grant Agreement.

(a) All funding is contingent upon the appropriation of funds by the Texas Legislature and upon approval of a grant application by the comptroller.

(b) If the comptroller makes an award, the comptroller shall notify the applicant of the award decision and shall provide a grant agreement to the applicant for signature if the grant agreement was not already submitted as part of the application.

(c) All award decisions shall be made at the sole discretion of the comptroller and are not appealable or subject to protest.

(d) A grant agreement shall require the comptroller to disburse funds as soon as practicable and shall require funds to be expended during the grant period except the agreement may provide for the reimbursement of certain pre-award costs. Funds for purchases are considered expended when the grant recipient is legally obligated to expend the funds. A legal obligation to expend funds requires an effective, binding contract. Anticipated contracts, contracts under negotiation, and the earmarking or budgeting of funds for a specified purpose do not satisfy the requirement for a legal obligation.

(e) Grant award payments are subject to Government Code, §403.055 and §403.0551.

(f) A grant agreement must be electronically signed by an official of the grant recipient who is authorized to bind the grant recipient.

(g) A qualified county may receive grants for their sheriff's office, constable's office and prosecutor's office. A qualified county with more than one qualified prosecutor's office may receive more than one prosecutor's grant.

§16.304. Authorized uses of Grant Funds; Limitations.

(a) A rural sheriff's office salary assistance grant awarded under this subchapter and Local Government Code, §130.911, may only be used:

(1) to provide a minimum annual salary of at least:

(A) $75,000 for the county sheriff;

(B) $45,000 for each deputy sheriff [~~who performs motor vehicle stops in the routine performance of their duties~~]; and

(C) $40,000 for each jailer [~~whose duties include the safekeeping of prisoners and the security of a jail operated by the county~~]; and

(2) provided that each county sheriff that meets the definition in §16.300(2) [~~§16.300(3)~~] of this title, [~~and~~] each deputy sheriff that meets the definition in §16.300(3) [~~§16.300(4)~~] of this title, and [~~county~~] jailer that meets the definition in §16.300(9) [~~§16.300(2)~~] of this title that is employed by the county sheriff, regardless of hiring date, receives the minimum salary described by paragraph (1) of this subsection:[~~,~~]

(A) to increase the salary of a person described by paragraph (1) of this subsection;

(B) to hire additional deputies or staff for the sheriff's office; or

(C) to purchase vehicles, firearms, and safety equipment for the sheriff's office.

(b) A rural constable's office salary assistance grant awarded under this subchapter and Local Government Code, §130.912:

(1) may only be used to provide a minimum annual salary of $45,000 to a qualified constable; and

(2) for each qualified constable whose salary is funded in part by the grant awarded under this subchapter, the county must contribute at least 75% of the money required to meet the minimum annual salary requirement.

(c) A rural prosecutor's office salary assistance grant awarded under this subchapter and Local Government Code, §130.913, may only be used:

(1) to increase the salary of an assistant attorney, an investigator, or a victim assistance coordinator employed at the prosecutor's office; or

(2) to hire additional staff for the prosecutor's office.

(d) Grant funds may not be used for indirect costs or direct administrative costs of a grant recipient. Unallowable direct administrative costs include software, trainings, licenses and expenses for the business functions of the office. Grant funds may not be used for contract labor, but a grant recipient may hire an employee with a predetermined termination date. [~~A minimum annual salary as described in subsections (a)(1) and (b)(1) of this section does not include any overtime compensation. A salary increase includes increases required to bring a salary to the minimum annual salary as described by subsections (a)(1) and (b)(1) of this section, and salary increases described by subsections (a)(2)(A) and (c)(1) of this section, and will be measured based on the salary provided on the last day of the entity's fiscal year ending in 2023, excluding any overtime. The cost of a salary increase as described in this section includes the increase of legally required nonmonetary benefits and taxes for that salary. A salary increase does not include overtime and the cost of a salary increase does not include an increase of legally required nonmonetary benefits and taxes for overtime compensation. For example, in Fiscal Year 2023, a county sheriff's minimum annual salary is $50,000 and the county pays $3825.00 for the employer's share of payroll taxes, pays $2500 to Texas County and District Retirement System (TCDRS) for an employer's matching retirement contribution, and $2500 for health insurance premiums. In Fiscal Year 2024, because of the grant, the annual salary is $75,000, the employer's share of payroll taxes is $5737.50, the employer's matching contribution to TCDRS is $3750, and health insurance premiums are $2500. The county may use grant funds to increase the sheriff's annual budget by $25,000 + $1912.50 + $1250 = $28,162.50. A county may only use grant funds for the legally required nonmonetary benefits and taxes for a salary if the county provides the minimum annual salary required by subsections (a)(1) and (b)(1) of this section, if applicable. A county may not reduce a salary below a minimum salary required by subsection (a)(1) or (b)(1) of this section in order to use grant funds for legally required nonmonetary benefits and taxes for that salary.~~]

(e) For the purpose of subsection (a)(1) of this section, if a grant recipient does not have sufficient grant funding to fund the minimum annual salaries required by this subsection, the grant recipient may use grant funds to increase the salaries of the persons described in that subsection on a pro-rata basis.

(f) If a person described by subsection (a)(1) or (b)(1) of this section is a part-time or hourly employee, or holds a dual office or otherwise divides work hours between a position described in this section and another position, the minimum annual salary required by this section may be converted to a minimum hourly wage and will apply only to the hours of work performed for a position described in this section.

(1) For [~~for~~] an employee with a 40-hour work week, the minimum hourly wage shall be the product of:

(A) the minimum annual salary described in this section; and

(B) a quotient:

(i) the numerator of which is equal to the number of hours the employee normally works performing duties for a position described in this section each week, not to exceed 40; and

(ii) the denominator of which is equal to 40; and

(2) for an employee with a county adopted work period as authorized by the Fair Labor Standards Act, 29 U.S.C.A. § 207(k), the minimum hourly wage shall be the product of:

(A) the minimum annual salary described in this section; and

(B) a quotient:

(i) the numerator of which is equal to the number of hours the employee normally works performing duties for a position described in this section each period, not to exceed the number of hours that are nonovertime as determined under the Fair Labor Standards Act; and

(ii) the denominator of which is equal to the number of hours that are nonovertime as determined under the Fair Labor Standards Act.

(g) For grants awarded under Local Government Code, §130.911 or §130.912, grant funds may only be used for the state purpose of ensuring professional law enforcement throughout the state. For grants awarded under Local Government Code, §130.913, grant funds may only be used for the state purpose of ensuring professional legal representation of the people's interests throughout the state.

(h) A person whose salary increase may be paid with grant funds under subsections (a)(2)(A) or (c)(1) of this section may be paid an increase in hourly wages if they are paid an hourly wage rather than an annual salary.

(i) For salary increases required to bring a salary to the minimum annual salary as described by subsections (a)(1) and (b)(1) of this section, and salary increases described by subsections (a)(2)(A) and (c)(1) of this section:

(1) the cost of providing a salary increase includes:

(A) the amount by which the salary increases;

(B) excluding benefits and taxes paid for overtime pay, the amount by which the legally required nonmonetary benefits and taxes for that employee increases as a result of the salary increase, including:

(i) the increase in the employer's share of payroll taxes; and

(ii) if applicable, any increase in the employer's share of retirement contributions.

(2) The cost of providing a salary increase does not include:

(A) overtime pay;

(B) compensatory time pay that is paid out;

(C) longevity pay; or

(D) any legally required nonmonetary benefit that is not calculated as a percentage of salary or wages.

(3) The increase in a salary is measured based on the salary provided on the last day of the entity's fiscal year ending prior to the first year the entity received grant funds.

(4) A county may only use grant funds for the legally required nonmonetary benefits and taxes for a salary if the county provides the minimum annual salary required by subsections (a)(1) and (b)(1) of this section, if applicable. A county may not reduce a salary below a minimum salary required by subsection (a)(1) or (b)(1) of this section in order to use grant funds for legally required nonmonetary benefits and taxes for that salary.

(5) For example, in Fiscal Year 2023, a county sheriff's minimum annual salary is $50,000 and the county pays $3,825 for the employer's share of payroll taxes, pays $2,500 to Texas County and District Retirement System (TCDRS) for an employer's matching retirement contribution, and $2,500 for health insurance premiums. In Fiscal Year 2024, because of the grant, the annual salary is $75,000, the employer's share of payroll taxes is $5,737.50, the employer's matching contribution to TCDRS is $3,750, and health insurance premiums are $2,500. The county may use grant funds to increase the sheriff's annual budget by $25,000 + $1,912.50 + $1,250 = $28,162.50. In Fiscal Year 2025, because of the grant, the county may use grant funds to continue to fund the increase to the sheriff's annual budget for the annual salary increase by $25,000 + $1,912.50 + $1,250 = $28,162.50.

(j) For additional employees hired under subsections (a)(2)(B) or (c)(2) of this section:

(1) the cost of hiring the additional employees includes:

(A) the salary, which, if applicable, must meet the minimum annual salary required by subsections (a)(1) and (b)(1) of this section; and

(B) the legally required nonmonetary benefits and taxes for that employee, including:

(i) the employer's share of payroll taxes;

(ii) if applicable, the employer's share of retirement contributions; and

(iii) if applicable, the employer's share of health insurance premiums.

(2) The cost of hiring the additional employees does not include:

(A) overtime pay;

(B) compensatory time pay that is paid out; or

(C) longevity pay.

(3) Determination of whether an employee is an additional employee is based on whether the position existed on the last day of the entity's fiscal year ending prior to the first year the entity received grant funds.

(4) For the additional position to be eligible for salary increases funded by the grant, it must be an eligible salary increase under subsection (a)(2)(A) or (c)(1) of this section.

(5) For example, in Fiscal Year 2024, a county hires a new deputy sheriff with the following costs: a salary of $50,000, $3,825 for the employer's share of payroll taxes, $2,500 to Texas County and District Retirement System (TCDRS) for an employer's matching retirement contribution, and $2,500 for health insurance premiums. Total Fiscal Year 2024 allowable costs are $58,825. In Fiscal Year 2025, the county continues to employ this deputy sheriff and provides a salary increase of $2,500 resulting in an $192 increase in the employer's share of payroll taxes, an $192 increase in the employer's matching retirement contribution, and no increase in health insurance premiums. This position is eligible for a salary increase under subsection (a)(2)(A) of this section. Total Fiscal Year 2025 allowable costs for this position are $61,709, which include the same amount of $58,825 that it cost to create the position in FY 2024 plus the cost of $2,884 to increase the salary.

(k) For vehicle leases to be considered a purchase as described in subsection (a)(2)(C) of this section, the grant recipient must:

(1) have the right to purchase the vehicle on performing conditions stated in the agreement, and

(2) have an immediate right to possess the vehicle.

§16.305. Reporting and Compliance.

(a) A grant recipient shall submit a compliance report certifying compliance and detailing expenditures of grant funds using the comptroller's electronic form. The comptroller may request supporting documentation regarding expenditures and any other information required to substantiate that grant funds are being used for the intended purpose and that the grant recipient has complied with the terms, conditions, and requirements of the applicable statute, the grant agreement and this subchapter. Any information requested by the comptroller must be submitted by the grant recipient within 14 calendar days of the request.

(b) Grant recipients must comply with:

(1) the terms and conditions of the grant agreement;

(2) the requirements of Local Government Code, §§130.911, 130.912, or 130.913, as applicable;

(3) the relevant provisions of the Texas Grant Management Standards and the State of Texas Procurement and Contract Management Guide, or their successors, adopted in accordance with Texas law; and

(4) all applicable state or federal statutes, rules, regulations, or guidance applicable to the grant award, including this subchapter.

(c) If the comptroller finds that a grant recipient has failed to comply with any requirement described in subsection (b) of this section, the comptroller may:

(1) require the grant recipient to cure the failure to comply to the satisfaction of the comptroller;

(2) [(1)] require the grant recipient to return the grant award or a portion of the grant award;

(3) [(2)] withhold grant award amounts from the current grant or future grants to be received by a grant recipient pending correction of the deficiency;

(4) [(3)] disallow all or part of the cost of the activity or action that is not in compliance;

(5) [(4)] terminate the grant award in whole or in part;

(6) [(5)] bar the grant recipient from future consideration for grant funds under this subchapter; or

(7) [(6)] exercise any other legal remedies available at law.

(d) The compliance report must be electronically signed by an official of the grant recipient who is authorized to bind the grant recipient. The authorized official must certify that all information in the compliance report is true and correct and will be responsible for providing any additional documents requested by the comptroller.

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

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405254
Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 475-2220

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 7. RAIL FACILITIES

SUBCHAPTER D. RAIL SAFETY

43 TAC §7.35, §7.36

The Texas Department of Transportation (department) proposes the amendments to §7.35 and §7.36 concerning Rail Safety.

EXPLANATION OF PROPOSED AMENDMENTS

Section 7.35 requires railroads to annually report information about hazardous material shipments to the department. Section 7.36 implements Texas Transportation Code, Chapter 191, which provides standards to protect workers from hazards caused by unsafe proximity of structures near railroad tracks and authorizes the department to grant a request to deviate from a requirement of that chapter. Amendments to §7.35 and §7.36 are required to maintain consistency with modern railroad industry best practices for reporting hazardous material shipping and to improve the efficiency of compliance with safety regulations. The amendments support emergency preparedness and reduce administrative burdens for state agencies and railroads.

Amendments to §7.35, Hazardous Materials - Written Reports, remove unused definitions, update and clarify language to match modern industry standards, and update the content of reporting by requiring reporting of more specific data on a per-county basis.

Amendments to §7.36, Clearances of Structures Over and Alongside Railway Tracks, change the process used for the department to grant applications to deviate from a requirement of Texas Transportation Code, Chapter 191. The rule currently requires the Texas Transportation Commission (commission) to consider such a waiver request. However, the department rail division staff receives the waiver requests and determines

the safety of proposed clearance deviations, whether any conditions should be imposed, and whether to recommend that the commission approve the request. Requiring the approval from the commission adds several months to the process without increasing safety outcomes. The amendment will permit the department's executive director, or a designee, to issue final approval of the waiver, which will reduce administrative steps and expedite projects without reducing safety.

FISCAL NOTE

Stephen Stewart, Chief Financial Officer, has determined, in accordance with Government Code, §2001.024(a)(4), that for each of the first five years in which the proposed rules are in effect, there will be no fiscal implications for state or local governments as a result of the department's or commission's enforcing or administering the proposed rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

Mr. Jeff Davis, Director, Railroad Division, has determined that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the proposed rules and therefore, a local employment impact statement is not required under Government Code, §2001.022.

PUBLIC BENEFIT

Mr. Davis has determined, as required by Government Code, §2001.024(a)(5), that for each year of the first five years in which the proposed rules are in effect, the public benefit anticipated as a result of enforcing or administering the rules will be significant decreases in delays experienced by local governments and shippers for the execution of certain railroad improvement projects, and better, clearer data delivery to planning organizations that will increase emergency preparedness.

COSTS ON REGULATED PERSONS

Mr. Davis has also determined, as required by Government Code, §2001.024(a)(5), that for each year of that period there are no anticipated economic costs for persons, including a state agency, special district, or local government, required to comply with the proposed rules and therefore, Government Code, §2001.0045, does not apply to this rulemaking.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities, as defined by Government Code, §2006.001, and therefore, an economic impact statement and regulatory flexibility analysis are not required under Government Code, §2006.002.

GOVERNMENT GROWTH IMPACT STATEMENT

Mr. Davis has considered the requirements of Government Code, §2001.0221 and anticipates that the proposed rules will have no effect on government growth. He expects that during the first five years that the rule would be in effect:

(1) it would not create or eliminate a government program;

(2) its implementation would not require the creation of new employee positions or the elimination of existing employee positions;

(3) its implementation would not require an increase or decrease in future legislative appropriations to the agency;

(4) it would not require an increase or decrease in fees paid to the agency;

(5) it would not create a new regulation;

(6) it would not expand, limit, or repeal an existing regulation;

(7) it would not increase or decrease the number of individuals subject to its applicability; and

(8) it would not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

Mr. Davis has determined that a written takings impact assessment is not required under Government Code, §2007.043.

SUBMITTAL OF COMMENTS

Written comments on the amendments to §7.35 and §7.36, may be submitted to Rule Comments, General Counsel Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "Railroad Safety Rules" The deadline for receipt of comments is 5:00 p.m. on December 16, 2024. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §111.101, which authorizes the commission to adopt rules to implement federal safety laws, and §191.004, which authorizes the commission to adopt rules to implement Transportation Code, Chapter 191, relating to structures and materials near railroad or railway.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapters 111 and 191.

§7.35. Hazardous Materials--Written Reports.

(a) Policy. It is the policy of the department to provide information regarding the type and quantity of hazardous materials transported within the state to the Texas Division of Emergency Management for use by local emergency planning agencies in areas containing reported railroad operations. It is also department policy to collect such information in order for the department to more efficiently allocate hazardous materials inspection resources. To accomplish these policies, each railroad that transports a hazardous material into, out of, within, or through the state is required to adhere to certain reporting requirements relating to the transportation of hazardous materials.

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

[~~(1) Emergency management program--An emergency management program established under Government Code, Chapter 418, Subchapter E.~~]

(1) [~~(2)~~] Hazardous material--Any substance transported by a railroad which is included within the requirements of the railcar placarding regulations adopted by the United States Department of Transportation and published in the C.F.R., Title 49.

(2) [(3)] Railroad line [segment]--A length of railroad that is designated in the current railroad timetable. The term includes a railroad subdivision, branch line, industrial lead, and spur line. The term does not include a business track. [line over which hazardous materials are transported between two or more municipalities within the state that are also identified as stations on a current railroad timetable. A line segment will terminate at the nearest municipality where the frequency of cars-per-year transporting hazardous materials changes from one category, as defined in subsection (d)(2) of this section, to another.]

(3) [(4)] Reporting year--Calendar year (January 1-December 31) preceding the year the report is to be submitted.

(c) Reporting requirements. A railroad that transports hazardous materials in or through the state is required to file the following information with the department:

(1) when the department makes a written request, a copy of the report of each hazardous materials incident occurring within the state of Texas that the railroad company files with the United [Unites] States Department of Transportation under 49 C.F.R. §171.16;

(2) a map delineating the geographical limits of the railroad operating divisions or districts, [and] the principal operating officer for the railroad in each operating division or district in the state, and the current timetable for railroad operations in the divisions or districts;

(3) a primary and secondary telephone number, which are manned 24 hours per day, for the railroad dispatcher responsible for train operations in each operating division or district in the state;

(4) the name and contact information [address] of each [the] railroad employee who is responsible for [in charge of] managing hazardous materials transportation in the state for the railroad; and

(5) for each county, a hazardous materials commodity report that satisfies subsection (d) of this section and that shows each type of hazardous material transported in the state during the reporting year over each railroad line [segment] owned, leased, or operated by the railroad or railroad line over which hazardous material was transported by trackage rights or haulage rights [in the state during the reporting year].

(d) Contents of hazardous materials commodity report.

(1) A hazardous materials commodity report, at a minimum, must contain:

(A) the county name;

(B) the railroad line name;

(C) the Standard Transportation Commodity Code for the hazardous material;

(D) the United Nations (UN)/ North American (NA) number assigned to the hazardous material;

(E) the packing group of the hazardous material;

(F) the proper shipping name of the hazardous material;

(G) the current Emergency Response Guidebook number for the hazardous material, if applicable;

(H) the United States Department of Transportation's hazard class and division for the hazardous material as assigned by 49 C.F.R. Part 173 or the identification designation specified in 40 C.F.R. Part 261;

(I) the total number of residue cars transported in the county during the reporting year;

(J) the total number of loaded cars transported in the county during the reporting year;

(K) the total number of residue intermodal containers transported in the county during the reporting year;

(L) the total number of loaded intermodal containers transported in the county during the reporting year; and

(M) the sum of the numbers reported under subparagraphs (I), (J), (K), and (L) for the county.

(2) The railroad must label a hazardous materials commodity report as sensitive security information if the report contains information defined as sensitive security information under 49 C.F.R. Part 1520.

[(1) The type of hazardous material transported shall be identified by hazard class as defined by 49 C.F.R. Part 173, or 40 C.F.R. Part 261.]

[(2) The quantity of hazardous materials transported shall be classified into the following five categories depending on the number of shipments of hazardous materials transported in a year]:

[(A) more than 10,000 cars-per-year;]

[(B) 5,001 to 10,000 cars-per-year;]

[(C) 1,001 to 5,000 cars-per-year;]

[(D) 501 to 1,000 cars-per-year;]

[(E) 51 to 500 cars-per-year;]

[(F) one to 50 cars-per-year.]

[(3) Texas counties traversed by each railroad line segment shall be identified.]

[(4) The applicable railroad operating division or district shall be identified for each railroad line segment. A railroad line segment shall not traverse more than one railroad operating division or district.]

(e) Reporting dates. Information [Reports] required by subsection (c)(2) - (5) of this section shall be filed with the department not later than April 1 of each year.

(f) Format. A railroad shall provide the information required by this section in the format [Forms. Reporting shall be made as] prescribed by the department.

(g) Variance. A railroad may request that the department grant a variance from the requirements of this section. The department shall process the application in accordance with §7.42 of this subchapter (relating to Administrative Review). The department may approve the variance only if the department will continue to receive information concerning the transportation of hazardous materials needed by local emergency planning agencies and needed to efficiently allocate the department's inspection resources. Any exception granted by the department shall be valid for a period not to exceed two years.

§7.36. Clearances of Structures Over and Alongside Railway Tracks.

(a) The lowest part of a structure built over the tracks of a railroad, including a bridge, viaduct, foot bridge, or power line, may not be less than 22 feet above the top of the rails of the tracks.

(b) A structure, including a platform or fence, or material may not be built or placed so that any part of the structure or material is less than 8-1/2 feet from the center line of a railroad track, including a main line, spur, switch, or siding.

(c) The lowest part of a roof projection constructed for any purpose may not be less than 22 feet above the top of the rails of a railroad track and the horizontal edge of the roof projection may not be less than 8-1/2 feet from the center line of the track.

(d) Transportation Code, §191.001 and §191.002 and the requirements of this section do not apply to engine houses or buildings into which locomotives or cars are moved for terminal inspection, attention, or repairs.

(e) Waiver of Provision.

(1) An individual or entity may apply for a waiver from the requirements of Transportation Code, §191.001 and §191.002, or this section, on a form to be prescribed by the department and provided on the department web site.

(2) The department will [~~shall~~] process the application. On a showing of good cause by the applicant and after the department's notice to the attorney general, as required under Transportation Code, §191.005, the executive director or a designee may grant all or a part of [~~and submit it to the commission for final action. The commission shall grant, grant in part, or deny~~] the waiver request. The executive director or a designee [~~commission~~] may require appropriate measures such as posting warning signs and giving notice to railroads that use the facility.

(3) If the applicant does not provide sufficient information to evaluate the waiver request, the executive director or a designee [~~commission~~] will deny the request.

(4) The applicant is not entitled to a contested case hearing, and there is no right to appeal the [~~commission~~] decision on the waiver 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.

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405217
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 463-8630

CHAPTER 11. DESIGN

The Texas Department of Transportation (department) proposes the amendments to §§11.51, 11.54, and 11.55, the repeal of §11.53, and new §11.59 and §11.60, all concerning Access Connections to State Highways.

EXPLANATION OF PROPOSED AMENDMENTS, REPEAL, AND NEW SECTIONS

This rulemaking provides the authority for district engineers to approve a driveway permit in an area where the department owns the access rights but only if the driveway can be safely installed and maintained. The grant of this authority provides an alternative to the current process under which a property owner must purchase access rights from the department in such a circumstance.

Amendments to §11.51, Definitions, clarify the definitions of "access connection", "commercial driveway", and "private driveway". The amendments also revise the definition of "executive director" to eliminate references to a position that no longer exists at the department. The definition of "access denial line" is added to identify where the department owns all rights of access from the adjacent property to the state highway.

Section 11.53, Locations Where the Department Controls the Access, is repealed and is replaced with new §11.60, Sale of Access at Locations Where the Department Owns the Access. The new §11.60, Sale of Access at Locations Where the Department Owns the Access, addresses the process by which the commission may sale the right of access to the adjacent landowner.

Amendments to §11.54, Construction and Maintenance of Access Connection Facilities, add subsection (c)(3) to clarify that the department may, but is not required, to reconstruct a driveway that has been permitted across an access denial line pursuant to the new §11.59 (relating to Permit of Access at Locations Where the Department Owns the Access).

Amendments to §11.55, Appeal Process, add a new subsection (b) to clarify that a district engineer's denial of an access permit requested under §11.59 (relating to Permit of Access at Locations Where the Department Owns the Access)is final and not subject to appeal by the property owner requesting such access. The amendments redesignate existing subsection (b) and following subsections and references to those redesignated subsections appropriately.

New §11.59, Permit of Access at Locations Where the Department Owns the Access, sets forth the process by which the district engineer may permit an adjoining landowner to access the state highway in locations where the department owns the access rights. This new section also requires that the adjoining landowner pay a permit fee that is predicated on the type of access being granted prior to the department's issuance of the access permit.

New §11.60, Sale of Access at Locations Where the Department Owns the Access, sets forth the process by which the commission may sale the right of access to the adjacent property owner. This new section is a restatement of the substance of existing §11.53, which is being repealed in this rulemaking to relocate its content to a more logical position within the subchapter.

FISCAL NOTE

Stephen Stewart, Chief Financial Officer, has determined, in accordance with Government Code, §2001.024(a)(4), that for each of the first five years in which the proposed rules are in effect, there will be no fiscal implications for state or local governments as a result of the department's or commission's enforcing or administering the proposed rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

Mr. Kyle Madsen, Director, Right of Way Division, has determined that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the proposed rules and therefore, a local employment impact statement is not required under Government Code, §2001.022.

PUBLIC BENEFIT

Mr. Kyle Madsen has determined, as required by Government Code, §2001.024(a)(5), that for each year of the first five years in which the proposed rules are in effect, the public benefit anticipated as a result of enforcing or administering the rules will provide a faster alternative process for adjacent landowners to obtain access in those locations where the department owns the access rights. This alternative method will lower the costs the adjacent landowners must incur to currently obtain access and thus help maintain Texas's probusiness environment.

COSTS ON REGULATED PERSONS

Mr. Madsen has also determined, as required by Government Code, §2001.024(a)(5), that for each year of that period there are no anticipated economic costs for persons, including a state agency, special district, or local government, required to comply with the proposed rules and therefore, Government Code, §2001.0045, does not apply to this rulemaking. The proposed rules and associated fees provide adjacent landowners an alternative method to the current method of purchasing the access rights in order to obtain access to a highway facility in those locations where the department owns all rights of access. This alternative method reduces the burden and responsibilities imposed on persons affected by the rule and provides such a person with an option that decreases the costs for obtaining access to a highway facility in those locations.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities, as defined by Government Code, §2006.001, and therefore, an economic impact statement and regulatory flexibility analysis are not required under Government Code, §2006.002.

GOVERNMENT GROWTH IMPACT STATEMENT

Mr. Madsen has considered the requirements of Government Code, §2001.0221 and anticipates that the proposed rules will have no effect on government growth. He expects that during the first five years that the rule would be in effect:

(1) it would not create or eliminate a government program;

(2) its implementation would not require the creation of new employee positions or the elimination of existing employee positions;

(3) its implementation would not require an increase or decrease in future legislative appropriations to the agency;

(4) it would require an increase or decrease in fees paid to the agency;

(5) it would not create a new regulation;

(6) it would not expand, limit, or repeal an existing regulation;

(7) it would not increase or decrease the number of individuals subject to its applicability; and

(8) it would not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

Mr. Madsen has determined that a written takings impact assessment is not required under Government Code, §2007.043.

PUBLIC HEARING

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct a public hearing to receive comments concerning the proposed rules. The public hearing will be held at 9:00 a.m. on November 25, 2024, in the Ric Williamson Hearing Room, First Floor, Dewitt C. Greer State Highway Building, 125 East 11th Street, Austin, Texas and will be conducted in accordance with the procedures specified in 43 TAC §1.5. Those desiring to make comments or presentations may register starting at 8:30 a.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact the General Counsel Division, 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-8630 at least five working days before the date of the hearing so that appropriate services can be provided.

SUBMITTAL OF COMMENTS

Written comments on the amendments to §§11.51, 11.54, and 11.55, the repeal of §11.53, and new §11.59 and §11.60, may be submitted to Rule Comments, General Counsel Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "*Access Permits*" The deadline for receipt of comments is 5:00 p.m. on December 16, 2024. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

SUBCHAPTER C. ACCESS CONNECTIONS TO STATE HIGHWAYS

43 TAC §§11.51, 11.54, 11.55, 11.59, 11.60

STATUTORY AUTHORITY

The amendments and new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §203.031, which provides the commission with the authority to control access to highways.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapter 203, Subchapter C, Control of Access.

§11.51. Definitions.

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

(1) Access connection--Facility, [~~for entry and/or exit~~] such as a driveway, street, road, or highway, that connects to a highway on the state highway system for entry or exit.

(2) Access denial line--The boundary line between the right-of-way of a state highway and adjacent property where the

department owns all rights of access from the adjacent property to the state highway.

(3) [~~(2)~~] Access management standards--The standards, criteria, and specifications prescribed in Chapter 2, Access Management Standards, of the department's Access Management Manual that govern the location, design, construction, and maintenance of access connections.

(4) [~~(3)~~] Commercial driveway--An entrance to[~~,~~] or exit from a multifamily residential dwelling or a [~~, any~~] commercial, business, or similar type establishment.

(5) [~~(4)~~] Commission--The Texas Transportation Commission.

(6) [~~(5)~~] Construction of an access connection--The installation, construction, reconstruction, relocation, enlargement, or other material modification of an access connection.

(7) [~~(6)~~] Department--The Texas Department of Transportation.

(8) [~~(7)~~] Design division--The administrative office of the department responsible for the development of engineering design guidance and oversight of projects developed on the state highway system.

(9) [~~(8)~~] Development--The new construction or the enlargement of any exterior dimension of a building, structure, or improvement.

(10) [~~(9)~~] Director--The chief administrative officer in charge of the design division.

(11) [~~(10)~~] District--One of the 25 geographic districts into which the department is divided.

(12) [~~(11)~~] District engineer--The chief administrative officer in charge of the district in which the access connection is located, or that officer's designee.

(13) [~~(12)~~] Eligible county--A county with a population of 3.3 million or more or a county adjacent to a county with a population of 3.3 million or more.

(14) [~~(13)~~] Engineering study--An appropriate level of analysis as determined by the department, which may include a traffic impact analysis, that determines the expected impact that permitting access will have on mobility, safety, and the efficient operation of the state highway system.

(15) [~~(14)~~] Executive director--The executive director of the department, or a designee not below the level of deputy executive director [~~or assistant executive director~~].

(16) [~~(15)~~] Local access management plan--A plan or guideline in a formally adopted rule or ordinance that is related to the application of access management within the municipality's or eligible county's jurisdiction.

(17) [~~(16)~~] Local access road--A local public street or road, generally one parallel to a highway on the state highway system to which access for businesses or properties located between the highway and the local access road is provided as a substitute for access to the highway. A local access road may also be called a lateral road or reverse frontage road, depending on individual location and application.

(18) [~~(17)~~] Permit--Authorization for entry to or exit from a state highway and adjacent real property, issued by the department under Transportation Code, Chapter 203.

(19) [~~(18)~~] Permittee--A real property owner, or the owner's authorized representative, who receives an access connection permit from the department to construct or modify an access connection from the owner's property to a highway on the state highway system.

(20) [~~(19)~~] Platted access point--An access connection identified in a plat or replat of a subdivision of real property properly recorded in the county clerk's office in accordance with Property Code, §12.002.

(21) [~~(20)~~] Private driveway--An entrance to or exit from a single-family residential dwelling, farm, or ranch for the exclusive use and benefit of the permittee.

(22) [~~(21)~~] Public driveway--An approach from a publicly maintained street, road, or highway.

(23) [~~(22)~~] Regionally significant highway--A highway functionally classified as a minor arterial or higher.

(24) [~~(23)~~] Traffic impact analysis--A traffic engineering study to the level of analysis determined by the department that determines the potential current and future traffic impacts of a proposed traffic generator and is signed, sealed, and dated by an engineer licensed to practice in the state of Texas.

(25) [~~(24)~~] Undeveloped property--The real property identified in a plat or replat of a subdivision properly recorded in the county clerk's office in accordance with Property Code, §12.002, on which development has not commenced.

§11.54. Construction and Maintenance of Access Connection Facilities.

(a) Cost for commercial and private driveways. For commercial and private driveways, the cost of materials, installation, construction, reconstruction, relocation, enlargement, modification, and maintenance shall be the responsibility of the permittee, except as otherwise provided in subsection (c) of this section.

(b) Cost for public driveways. For public driveways, the cost of materials, installation, construction, reconstruction, relocation, enlargement, and modification shall be the responsibility of the permittee, except as otherwise provided in subsection (c) of this section. The department shall maintain all portions of public driveways that lie within the state highway right of way and that connect to highways that are the maintenance responsibility of the department.

(c) Reconstruction by department.

(1) Any existing access connections that are destroyed or removed in the construction or reconstruction of a section of highway will be reestablished by the department at the expense of the state to the extent necessary to provide reasonable access.

(2) If the department determines that the proposed construction or reconstruction of a section of highway will permanently alter permitted access to or from a state highway at an adjacent property owner's existing driveway location, the department will:

(A) provide the property owner with written notice of the highway project before the 60th day preceding the date construction of the highway project begins; and

(B) at the expense of the state, reinstate the pre-existing access to the most practicable extent possible after due consideration of the impact on highway safety, mobility, and efficient operation, and of any changes to traffic patterns that are likely to result from the highway construction or reconstruction.

(3) Paragraphs (1) and (2) of this subsection do not apply to an access connection that is located across an access denial line for which a permit is issued under §11.59 of this subchapter (relating to Permit of Access at Locations Where the Department Owns the Access). The department may, but is not required to, reconstruct such an access connection.

(d) Inspection. The department may inspect the construction of an access connection at the time the work is being performed and at any time after the work is completed. The permittee or the permittee's heirs, successors, and assigns shall make the changes or repairs that the district engineer reasonably determines are necessary to bring the access connection into compliance with terms and conditions of the permit. A decision to require a change or repair will be in writing, describe the actions to be performed, and provide a reasonable period for compliance.

(e) Drainage and safety. The department may undertake actions deemed necessary to correct drainage or safety problems related to existing or new access connection facilities.

§11.55. Appeal Process.

(a) A property owner or its authorized representative, as the applicant, may file a petition of appeal to contest:

(1) a requirement for a change or repair under §11.54(d) of this subchapter (relating to Inspection);

(2) the denial of a request for a variance under §11.52(e) of this subchapter (relating to Variance);

(3) a finding of significant impact and threat to public safety under §11.52(g) of this subchapter (relating to Remodeled business); or

(4) the denial of a request for a driveway permit under §11.52(b) of this subchapter (relating to Permit requirements).

(b) A district engineer's denial of a request for an access permit under §11.59 of this subchapter (relating to Permit of Access at Locations Where the Department Owns the Access) is final and a property owner has no right to appeal the denial.

(c) [~~(b)~~] The petition must be filed with the director before the 31st day after the date written notice of the denial, requirement, or finding is received by the applicant.

(d) [~~(c)~~] The petition must:

(1) be in writing;

(2) completely and succinctly state the grounds for appeal and its factual basis; and

(3) include sufficient factual documentation, such as drawings, surveys, or photographs, to establish the merits of the appeal.

(e) [~~(d)~~] The applicant has the burden of demonstrating that the department incorrectly applied its access connection requirements to the applicable facts.

(f) [~~(e)~~] For a petition that satisfies the requirements of this section, the director will issue, before the 91st day after the date of receipt of the petition, a written decision approving or disapproving the appeal and, on issuance, immediately send the decision to the applicant. If a written decision is not issued within the 90-day period, the appeal is considered to be approved and the request granted, subject to:

(1) purchase of access rights in accordance with §11.60 [~~§11.53~~] of this subchapter (relating to Sale of Access at Locations Where the Department Controls the Access) if the applicant has no existing right of access; and

(2) consent of the Federal Highway Administration in accordance with 23 C.F.R. §710.401 if the requested access connection is on an interstate highway.

(g) [~~(f)~~] To appeal a decision issued under subsection (f) [~~(e)~~] of this section, the applicant must submit its written petition of appeal to the executive director before the 31st day after the date that written notice of the decision is received. The petition must satisfy the requirements of subsection (d) [~~(c)~~] of this section. The executive director will issue, before the 31st day after the date of receipt of the petition, a written decision approving or disapproving the appeal.

(h) [~~(g)~~] To appeal a decision of the executive director issued under subsection (g) [~~(f)~~] of this section, the applicant must submit to the executive director its written petition of appeal to a board of variance, before the 31st day after the date that the executive director's decision under subsection (g) [~~(f)~~] of this section is received. On receipt of the petition, the procedure set out in this subsection applies.

(1) The executive director will appoint a board of variance composed of at least three persons, each of whom is not below the level of department division director, office director, or district engineer and was not involved in the original decision to deny the applicant's request. A majority of the members of the board constitutes a quorum.

(2) The board of variance will meet and consider the appeal. Before the 10th day preceding the date of the meeting, the board will give the applicant notice of the time and place of the meeting and afford the applicant an opportunity to attend and present evidence regarding the appeal.

(3) Before the 11th day after the date of the meeting, the board of variance will issue a final written decision approving or disapproving the appeal.

§11.59. Permit of Access at Locations Where the Department Owns the Access.

(a) Access permit requests. A request for a permit for a new access connection across an access denial line will be considered under this section. The district engineer, in the district engineer's sole discretion, may grant or deny a permit request under this section.

(b) Access permit request contents. A permit request must include:

(1) a description of the development or undeveloped property for which access is being requested;

(2) an engineering study that is acceptable to the department and that shows the safety of the requested access;

(3) all information required under §11.52(b) of this subchapter (relating to Access Connection Facilities); and

(4) any additional information relating to the requested permit that is requested by the department.

(c) Evaluation by the department. A permit request under this section must comply with all other access requirements of this subchapter.

(d) Access permit fees. If a permit request is approved, the requester must pay a permit fee in accordance with this subsection before the department will issue an access permit.

(1) The fee for a permit for a private driveway access is $250.

(2) The fee for a permit for a commercial driveway access is based on the most recent unadjusted market value of the land and improvements on the benefitted property determined by the local ap-

praisal district established under Tax Code, Chapter 6, Subchapter A. The fee is:
Figure: 43 TAC §11.59(d)(2)

(e) No rights of access conveyed. The issuance of a permit under this section does not convey any property right, including a right of access to the highway facility. The department, in its sole discretion, may revoke a permit issued under this section on its determination that the access location is needed for a highway purpose. Such a revocation may not be the basis for any claim of a constitutional taking of property for the loss of access to the highway facility.

§11.60. Sale of Access at Locations Where the Department Owns the Access.

(a) Access purchase request. A request to purchase a new access connection to a highway across an access denial line will be considered under this section. The request must include an engineering study acceptable to the department.

(b) Determination. The commission will make the final determination concerning the sale of access rights under this section. The commission may consider the findings of the engineering study, the mobility and safety of the highway system, and any other relevant factors.

(c) Sale procedure. A sale of access rights under this section is subject to Transportation Code, Chapter 202, Subchapter B. Access points approved by the commission under this section will be specifically described by a metes and bounds property description.

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 October 31, 2024.

TRD-202405218
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 463-3164

43 TAC §11.53

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §203.031, which provides the commission with the authority to control access to highways.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapter 203, Subchapter C, Control of Access

§11.53. Locations Where the Department Controls the Access.

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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Becky Blewett
Deputy General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-3164

CHAPTER 28. OVERSIZE AND OVERWEIGHT VEHICLES AND LOADS

SUBCHAPTER A. GENERAL PROVISIONS

43 TAC §28.2, §28.4

The Texas Department of Transportation (department) proposes the amendments to §28.2 and new §28.4 concerning Oversize and Overweight Vehicles and Loads.

EXPLANATION OF PROPOSED AMENDMENTS

After the legislature's creation of the Texas Department of Motor Vehicles (DMV), some of the department's duties and rules were transferred to the DMV, including the provision relating to permits issued for the movement of oversize vehicles on specified holidays. DMV recently identified that it does not have the statutory authority for such a provision and is in the process of changing its rules to delete the provision. The statutory authority to place holiday restrictions on oversize and overweight vehicles was not changed by the transfer of duties to the DMV and remains with the commission. This rulemaking clarifies that the size limitations previously established by the commission for the movement of oversize vehicles on specified holidays continue in effect.

Amendments to §28.2, Definitions, corrects an error in the definition of "permittee" in paragraph (11). Permits for oversize or overweight vehicles are issued by the DMV.

New §28.4, Holiday restrictions on size limits, clarifies that the maximum size limits for a permit issued for movement of a vehicle on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, or Christmas Day is 14 feet wide, 16 feet high, and 110 feet long, unless an exception is granted based on a route and traffic study conducted by the department.

FISCAL NOTE

Stephen Stewart, Chief Financial Officer, has determined, in accordance with Government Code, §2001.024(a)(4), that for each of the first five years in which the proposed rules are in effect, there will be no fiscal implications for state or local governments as a result of the department's or commission's enforcing or administering the proposed rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

James Stevenson, P.E., Director, Maintenance Division, has determined that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the proposed rules and therefore, a local employment impact statement is not required under Government Code, §2001.022.

PUBLIC BENEFIT

Mr. Stevenson has determined, as required by Government Code, §2001.024(a)(5), that for each year of the first five years in which the proposed rules are in effect, the public benefit anticipated as a result of enforcing or administering the rules will be convenience and public safety.

COSTS ON REGULATED PERSONS

Mr. Stevenson has also determined, as required by Government Code, §2001.024(a)(5), that for each year of that period there are no anticipated economic costs for persons, including a state agency, special district, or local government, required to comply with the proposed rules and therefore, Government Code, §2001.0045, does not apply to this rulemaking.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

There will be no adverse economic effect on small businesses, micro-businesses, or rural communities, as defined by Government Code, §2006.001, and therefore, an economic impact statement and regulatory flexibility analysis are not required under Government Code, §2006.002.

GOVERNMENT GROWTH IMPACT STATEMENT

Mr. Stevenson has considered the requirements of Government Code, §2001.0221 and anticipates that the proposed rules will have no effect on government growth. He expects that during the first five years that the rule would be in effect:

(1) it would not create or eliminate a government program;

(2) its implementation would not require the creation of new employee positions or the elimination of existing employee positions;

(3) its implementation would not require an increase or decrease in future legislative appropriations to the agency;

(4) it would not require an increase or decrease in fees paid to the agency;

(5) it would not create a new regulation;

(6) it would not expand, limit, or repeal an existing regulation;

(7) it would not increase or decrease the number of individuals subject to its applicability; and

(8) it would not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

Mr. Stevenson has determined that a written takings impact assessment is not required under Government Code, §2007.043.

SUBMITTAL OF COMMENTS

Written comments on the amendments to §28.2 and new §28.4 may be submitted to Rule Comments, General Counsel Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483 or to RuleComments@txdot.gov with the subject line "Oversize vehicle limits on holidays." The deadline for receipt of comments is 5:00 p.m. on December 16, 2024. In accordance with Transportation Code, §201.811(a)(5), a person who submits comments must disclose, in writing with the comments, whether the person does business with the department, may benefit monetarily from the proposed amendments, or is an employee of the department.

STATUTORY AUTHORITY

The new rule and amendments are proposed under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §621.006, which authorizes the commission to impose restrictions on the weight and size of vehicles to be operated on state highways on specified holidays.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, §621.006.

§28.2. Definitions.

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

(1) Axle--The common axis of rotation of one or more wheels whether power-driven or freely rotating, and whether in one or more segments.

(2) Axle group--An assemblage of two or more consecutive axles, with two or more wheels per axle, spaced at least 40 inches from center of axle to center of axle, equipped with a weight-equalizing suspension system that will not allow more than a 10% weight difference between any two axles in the group.

(3) Commission--The Texas Transportation Commission.

(4) Daylight--The period beginning one-half hour before sunrise and ending one-half hour after sunset.

(5) Department--The Texas Department of Transportation.

(6) Four-axle group--Any four consecutive axles, having at least 40 inches from center of axle to center of axle, whose extreme centers are not more than 192 inches apart and are individually attached to or articulated from, or both, to the vehicle by a weight equalizing suspension system.

(7) Gross weight--The unladen weight of a vehicle or combination of vehicles plus the weight of the load being transported.

(8) Motor carrier--A person that controls, operates, or directs the operation of one or more vehicles that transport persons or cargo over a public highway in this state.

(9) Overweight--An overdimension load that exceeds the maximum weight specified in Transportation Code, §621.101.

(10) Permitted vehicle--A vehicle, combination of vehicles, or vehicle and its load operating under the provisions of a permit.

(11) Permittee--Any person, firm, or corporation that is issued an oversize/overweight permit or temporary vehicle registration by the Texas Department of Motor Vehicles [~~MCD~~].

(12) Single axle--An assembly of two or more wheels whose centers are in one transverse vertical plane or may be included between two parallel transverse planes 40 inches apart extending across the full width of the vehicle.

(13) State highway--A highway or road under the jurisdiction of the Texas Department of Transportation.

(14) State highway system--A network of roads and highways as defined by Transportation Code, §221.001.

(15) Surety bond--An agreement issued by a surety bond company to a principal that pledges to compensate the department for any damage that might be sustained to the highways and bridges by virtue of the operation of the equipment for which a permit was issued. A surety bond is effective the day it is issued and expires at the end of

the state fiscal year, which is August 31st. For example, if you obtain a surety bond on August 30th, it will expire the next day at midnight.

(16) Three-axle group--Any three consecutive axles, having at least 40 inches from center of axle to center of axle, whose extreme centers are not more than 144 inches apart, and are individually attached to or articulated from, or both, to the vehicle by a weight equalizing suspension system.

(17) Trunnion axle--Two individual axles mounted in the same transverse plane, with four tires on each axle, that are connected to a pivoting wrist pin that allows each individual axle to oscillate in a vertical plane to provide for constant and equal weight distribution on each individual axle at all times during movement.

(18) Two-axle group--Any two consecutive axles whose centers are at least 40 inches but not more than 96 inches apart and are individually attached to or articulated from, or both, to the vehicle by a weight equalizing suspension system.

(19) Vehicle--Every device in or by which any person or property is or may be transported or drawn upon a public highway, except devices used exclusively upon stationary rails or tracks.

§28.4. Holiday Restrictions on Size Limits.

The maximum size limits for a permit issued under Transportation Code, Chapter 623, Subchapter D, for movement of a vehicle on a holiday listed in Transportation Code, §621.006, is 14 feet wide, 16 feet high, and 110 feet long, unless an exception is granted based on a route and traffic study conducted by the department.

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

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TRD-202405216
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 463-8630

ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 351. COORDINATED PLANNING AND DELIVERY OF HEALTH AND HUMAN SERVICES

SUBCHAPTER B. ADVISORY COMMITTEES

DIVISION 1. COMMITTEES

1 TAC §351.805

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §351.805, concerning State Medicaid Managed Care Advisory Committee.

Section 351.805 is adopted with changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5215). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The amendment is necessary to extend the State Medicaid Managed Care Advisory Committee (SMMCAC) and align the rule with HHSC advisory committee rule standards. Under the general authority of the Executive Commissioner, the SMMCAC was re-established in 2016 to consider managed care issues and make recommendations to HHSC. The SMMCAC is currently set to abolish on December 31, 2024. The rule amendment changes the SMMCAC abolish date from December 31, 2024, to December 31, 2028, which will allow SMMCAC to continue providing recommendations and ongoing input to HHSC on the statewide operation of Medicaid managed care programs for an additional four years. Additionally, the rule amendment restructures membership subcategories to increase representation for youth and adult populations and adds a new membership subcategory for persons transitioning from children to adult Medicaid managed care programs. The rule amendment will align §351.805 with agency standards for advisory committees by including a subsection on how eligible SMMCAC members may be reimbursed for travel.

COMMENTS

The 31-day comment period ended August 19, 2024.

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

HHSC revised §351.805(a) and subsection (h)(3) to update two Texas Government Code citations to implement House Bill 4611, 88th Legislature, Regular Session, 2023, which makes non-substantive revisions to the Texas Government Code that make the statute more accessible, understandable, and usable. These changes were not in response to a public comment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Government Code §531.012, which authorizes the Executive Commissioner to establish advisory committees by rule.

§351.805. State Medicaid Managed Care Advisory Committee.

(a) Statutory authority. The State Medicaid Managed Care Advisory Committee (SMMCAC) is established under Texas Government Code §523.0201 and is subject to §351.801 of this division (relating to Authority and General Provisions).

(b) Purpose. The SMMCAC advises the Texas Health and Human Services Commission (HHSC) executive commissioner and the health and human services system (HHS) on the statewide operation of Medicaid managed care, including:

(1) program design and benefits;

(2) systemic concerns from consumers and providers;

(3) efficiency and quality of services;

(4) contract requirements;

(5) provider network adequacy;

(6) trends in claims processing; and

(7) other issues as requested by the HHSC executive commissioner.

(c) Tasks. The SMMCAC performs the following tasks:

(1) makes recommendations to HHSC;

(2) advises HHSC on Medicaid managed care issues;

(3) disseminates Medicaid managed care best practice information as appropriate;

(4) adopts bylaws to guide the operation of the SMMCAC; and

(5) performs other tasks consistent with its purpose.

(d) Reporting requirements.

(1) Report to the HHSC executive commissioner. No later than December 31st of each year, the SMMCAC files an annual written report with the HHSC executive commissioner covering the meetings and activities in the immediately preceding fiscal year. The report includes:

(A) a list of the meeting dates;

(B) the members' attendance records;

(C) a brief description of actions taken by the SMMCAC;

(D) a description of how the SMMCAC accomplished its tasks;

(E) a summary of the status of any recommendations that the SMMCAC made to HHSC;

(F) a description of activities the SMMCAC anticipates undertaking in the next fiscal year;

(G) recommended amendments to this section; and

(H) the costs related to the SMMCAC, including the cost of HHSC staff time spent supporting the SMMCAC's activities and the source of funds used to support the SMMCAC's activities.

(2) Report to the Texas Legislature. By December 31st of each even-numbered year, the SMMCAC files a written report with the Texas Legislature of any policy recommendations made to the HHSC executive commissioner.

(e) Meetings.

(1) Open meetings. The SMMCAC complies with the requirements for open meetings under Texas Government Code Chapter 551 as if it were a governmental body.

(2) Frequency. The SMMCAC will meet quarterly.

(3) Quorum. Thirteen members constitute a quorum.

(f) Membership.

(1) The SMMCAC is composed of no more than 24 members appointed by the HHSC executive commissioner. In selecting members to serve on the SMMCAC, HHSC:

(A) considers the applicant's qualifications, background, and interest in serving; and

(B) tries to choose committee members who represent the diversity of all Texans, including ethnicity, gender, and geographic location.

(2) The SMMCAC consists of representatives of the following categories:

(A) ten people who are enrolled in Medicaid managed care or represent a person enrolled in Medicaid managed care and who are appointed from one or more of the following subcategories:

(i) a person who has low-income, a family member of the person, or an advocate representing people with low-income;

(ii) a person with an intellectual, a developmental, or a physical disability, including a person with autism spectrum disorder, or a family member of the person, or an advocate representing people with an intellectual, a developmental, or a physical disability, including persons with autism spectrum disorder;

(iii) a person using mental health services, a family member of the person, or an advocate representing people who use mental health services;

(iv) a person using non-emergency medical transportation services, a family member of the person, or an advocate representing persons using non-emergency medical transportation;

(v) a person who is dually enrolled in Medicaid and Medicare, a family member of the person, or an advocate representing persons who are dually enrolled in Medicaid and Medicare;

(vi) a family member of a child who is a Medicaid recipient or an advocate representing children who are Medicaid recipients, except for a child with special health care needs listed in clause (vii) of this subparagraph;

(vii) a family member of a child with special health care needs or an advocate representing children with special health care needs;

(viii) a person who is 18 years of age or older who will transition or has transitioned from a child and adolescent managed care program to an adult managed care program, a guardian of the person, or an advocate representing persons transitioning from a child and adolescent managed care program to an adult managed care program; or

(ix) a person who is 65 years of age or older, the person's family member, or an advocate representing persons who are 65 years of age or older;

(B) ten providers contracted with Texas Medicaid managed care organizations, appointed from one or more of the following subcategories:

(i) rural providers;

(ii) hospitals;

(iii) primary care providers;

(iv) pediatric health care providers;

(v) dentists;

(vi) obstetrical care providers;

(vii) providers serving people dually enrolled in Medicaid and Medicare;

(viii) providers serving people who are 21 years of age or older and have a disability;

(ix) non-physician mental health providers;

(x) long-term services and supports providers, including nursing facility providers and direct service workers; or

(xi) an organization, association, corporation that is representative of and located in, or in close proximity to, a community where it serves or conducts outreach for:

(I) people enrolled in Medicaid;

(II) children from families that are low-income;

(III) children with special health care needs;

(IV) people with disabilities;

(V) people 65 years of age or older; or

(VI) people needing perinatal care; and

(C) four managed care organizations participating in Texas Medicaid, including:

(i) national plans;

(ii) community-based plans; and

(iii) dental maintenance organizations (for the purpose of this section).

(3) HHSC appoints members for staggered terms so that terms of an equal or almost equal number of members expire on August 31st of each year. Regardless of the term limit, a member serves until

his or her replacement has been appointed. This ensures sufficient, appropriate representation.

(A) If a vacancy occurs, the HHSC executive commissioner will appoint a person to serve the unexpired portion of that term.

(B) Except as may be necessary to stagger terms, the term of each member is three years. A member may apply to serve one additional term.

(g) Officers. The SMMCAC selects a chair and vice chair of the committee from among its members.

(1) The chair serves until December 1st of each even-numbered year. The vice chair serves until December 1st of each odd-numbered year.

(2) A member may serve up to two consecutive terms as chair or vice chair.

(h) Required Training. Each member must complete training, which will be provided by HHSC, on relevant statutes and rules, including:

(1) this section;

(2) §351.801 of this division;

(3) Texas Government Code §523.0201;

(4) Texas Government Code Chapters 551, 552, and 2110;

(5) the HHS Ethics Policy;

(6) the Advisory Committee Member Code of Conduct; and

(7) other relevant HHS policies.

(i) Travel Reimbursement. To the extent permitted by the current General Appropriations Act, HHSC may reimburse a SMMCAC member for his or her travel to and from SMMCAC meetings only if:

(1) funds are appropriated and available; and

(2) the member:

(A) receives Medicaid services or is a family member of a client that receives Medicaid services; and

(B) submits the request for travel reimbursement in accordance with the HHSC Travel Policy.

(j) Date of abolition. The SMMCAC is abolished, and this section expires, on December 31, 2028.

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

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405215
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: November 20, 2024
Proposal publication date: July 19, 2024
For further information, please call: (512) 438-2910

TITLE 7. BANKING AND SECURITIES

PART 4. DEPARTMENT OF SAVINGS AND MORTGAGE LENDING

CHAPTER 55. RESIDENTIAL MORTGAGE LOAN ORIGINATORS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 55: §§55.1 - 55.6, 55.100 - 55.114, 55.200 - 55.205, 55.300 - 55.303, 55.310, and 55.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6864). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators (originators) licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Originator Rules from Chapter 81 to Chapter 55

SML has determined it should reorganize its rules concerning originators by relocating them to Chapter 55, a vacant chapter, and devoting such chapter exclusively to rules affecting originators. The adopted rules effectuate these changes.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §55.2, Definitions, adopt new definitions for "E-Sign Act," "making a residential mortgage loan," "person," "SML," "State Examination System," and "trigger lead," while eliminating definitions for "Commissioner's designee," and "Department"; in §55.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures an originator is required to make; in §55.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by an originator may be delivered and signed electronically; and, in §55.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Licensing (Subchapter B)

The adopted rules: in §55.100, Licensing Requirements, clarify when an originator license is required (including as it relates to a loan processor or underwriter who is an independent contractor); in §55.102, Fees, clarify that the license fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS), and clarify that an insufficient funds fee under Finance Code §157.013(d) may be charged if the originator makes a payment to SML by automated clearing house and that payment fails; in §55.103, Renewal of the License, clarify that a license approved with a pending deficiency is a conditional license and requires the originator to resolve the deficiency within 30 days after the date the license is approved, and clarify that, if a license is not renewed within the reinstatement period provided by Finance Code §157.016, the individual must apply for a new license; in §55.105, Conditional License, clarify the terms and conditions under which a conditional license may be granted; in §55.106, Surrender of the License, clarify circumstances under which SML may not grant a request made by the originator to surrender his or her license; in §55.107, Sponsorship of the Originator, clarify that an originator may be sponsored by more

than one mortgage company or mortgage banker, and establish requirements for an originator sponsored by more than one mortgage company or mortgage banker; in §55.108, Required Education, clarify that the pre-licensing examination required by Finance Code §180.057 means the uniform national examination approved by NMLS on or after April 1, 2013; and, in §55.109, Temporary Authority, clarify that the maximum duration for temporary authority under Finance Code §180.0511 is 120 days.

Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §55.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §156.004(a) or §157.0021(a) be signed by the originator and the mortgage applicant; in §55.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that an originator commits a violation if the originator knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that an originator commits a violation if the originator solicits a consumer on the federal do-not-call registry, clarify that an originator commits a violation if the originator issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that an originator commits a violation if the originator acts as an originator when his or her license is inactive; in §55.204, clarify that the books and records of an originator must be maintained by the mortgage company or mortgage banker sponsoring his or her license, and require that the originator work diligently and cooperatively with the mortgage company or mortgage banker to fulfill such requirements; and, in §55.205, Mortgage Call Reports, clarify that mortgage call reports are filed by the mortgage company or mortgage banker sponsoring the originator's license, and remove that seeming requirement.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §55.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §55.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §55.303, Corrective Action, clarify when SML may direct an originator to voluntarily take corrective action, and creating requirements for refunds made to consumers; in §55.310, Appeals, establish various deadlines by which an originator or other individual subject to an enforcement action must appeal; and, in §55.311, Hearings, clarify how hearing costs under Finance Code §157.017(f) are calculated.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§55.1 - 55.6

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(a), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

Filed with the Office of the Secretary of State on November 3, 2024.

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
Effective date: November 23, 2024
Proposal publication date: September 6, 2024
For further information, please call: (512) 475-1535

SUBCHAPTER B. LICENSING

7 TAC §§55.100 - 55.114

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §55.100 is also adopted under the authority of, and to implement, Finance Code: §§156.002(4-a), 156.004(a), 156.105(a), 157.012, 157.0021, 157.02012(a), 180.051, and 180.152. §55.101 is also adopted under the authority of, and to implement, Finance Code: §§157.013, 157.015, and §180.053. §55.102 is also adopted under the authority of, and to implement, Finance Code: §§157.013, 157.015, 180.058, and 180.061(2). §55.103 is also adopted under the authority of, and to implement, Finance Code: §157.0141, 157.015, 157.016, 180.059, and 180.060. §55.104 is also adopted under the authority of, and to implement, Finance Code §180.061. §55.105 is also adopted under the authority of, and to implement, Finance Code §157.0141. §55.106 is also adopted under the authority of, and to implement, Finance Code §180.061(4). §55.107 is also adopted under the authority of, and to implement, Finance Code: §157.019 and

§180.061(4). §55.108 is also adopted under the authority of, and to implement, Finance Code: §§180.056, 180.057, and 180.060. §55.109 is also adopted under the authority of, and to implement, Finance Code §180.0511. §55.110 is also adopted under the authority of, and to implement, Occupations Code Chapter 55. §55.111 and §55.112 are also adopted under the authority of, and to implement: Finance Code: §§157.0132, 180.054, 180.055, and 180.061(1); and Government Code §411.1385. §55.113 is also adopted under the authority of, and to implement, Occupations Code §53.025. §55.114 is also adopted under the authority of, and to implement, Occupations Code Chapter 53, Subchapter D.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
Effective date: November 23, 2024
Proposal publication date: September 6, 2024
For further information, please call: (512) 475-1535

SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§55.200 - 55.205

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §55.200 is also adopted under the authority of, and to implement, Finance Code: §§156.004, 157.0021, 180.061(4) and 180.151. §55.201 is also adopted under the authority of, and to implement, Finance Code: §§156.105, 157.0023(b), and 157.02012. §55.202 and §55.203 are also adopted under the authority of, and to implement, Finance Code: §§157.02015, 157.024(a)(2) and (3), 180.151, 180.152, and §180.153. §55.204 is also adopted under the authority of, and to implement, Finance Code: §157.02015(b) and §180.061(5). §55.205 is also adopted under the authority of, and to implement, Finance Code §157.020(a-1) and §180.101.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§55.300 - 55.303, 55.310, 55.311

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act. §§55.300 - 55.303 are also adopted under the authority of, and to implement, Finance Code: §§157.021, 157.0211, 157.025, 180.061(5), and 180.062. §55.310 is also adopted under the authority of, and to implement, Finance Code: §§157.017, 157.023, 157.024, and 157.031. §55.311 is also adopted under the authority of, and to implement, §157.017.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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CHAPTER 56. RESIDENTIAL MORTGAGE LOAN COMPANIES

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 56: §§56.1 - 56.6, 56.100 - 56.108, 56.200 - 56.206, 56.210, 56.300 - 56.304, 56.310, and 56.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6881). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 80, Residential Mortgage Loan Companies, affect residential mortgage loan companies (mortgage companies) licensed by SML under Finance Code Chapter 156 (Chapter 156).

Changes Concerning the Reorganization (Relocation) of Mortgage Company Rules from Chapter 80 to Chapter 56

SML has determined it should reorganize its rules concerning mortgage companies by relocating them to Chapter 56, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §56.2, Definitions, adopt new definitions for "E-Sign Act," "engage in or conduct the business of a mortgage company," "making a residential mortgage loan," "mortgage banker," "SML," "State Examination System," "trigger lead," "UETA," "wrap lender," and "wrap mortgage loan" while eliminating definitions for "Commissioner's designee," and "Department"; in §56.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage company is required to make; in §56.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage company may be delivered and signed electronically; and, in §56.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Licensing Requirements (§56.100)

The adopted rules, in §56.100, Licensing Requirements, clarify when a mortgage company license is required. §56.100(c) clarifies, among other things, the requirements of Finance Code §156.202(a-1)(3), which provides that an "owner of residential real estate who in any 12-consecutive month period makes no more than three residential mortgage loans to purchasers of the property for all or part of the purchase price of the residential real estate against which the mortgage is secured" (emphasis added) is exempt from the requirement to be licensed by SML as a mortgage company under Chapter 156 (meaning, a person who acts as the lender and makes more than three such loans is not exempt and must be licensed). In response to an early precomment draft of the rules published on SML's website, SML received an informal comment from the Texas Land Developers Association (TLDA) asserting that §56.100(c) seeks to impose licensing requirements on certain seller-finance mortgage lenders selling residential real estate (seller-finance lenders) currently operating under the belief that a mortgage company license is not required if the seller-finance lender secures the services of an entity licensed or registered by SML to provide residential mortgage loan origination services in making the loan, and that lender does not actually originate the mortgage loan. According to TLDA, this belief has its origins in informal guidance posted on SML's website as late as 2016 in the form of an answer to a "frequently asked question," as follows: "Q: May an individual or entity owner finance more than five properties within a 12 month period without being licensed if they use a licensed RMLO to facilitate the transaction?; A: Yes, assuming that they only act as the lender in the transaction and do not take an application or negotiate rate and terms with potential borrowers" (at that time, the statutory threshold for exempt transactions was five). However, the licensing requirements referenced by §56.100(c) are imposed by Finance Code §156.202(a-1)(3), not the rule, and the statute plainly states a mortgage company license is required for a person that makes (as the lender) more than the number of exempt transactions allowed under the statute. §56.100(c) clarifies the statutory requirements of Finance Code §156.202(a-1)(3) and dispels the belief that a license is not required under the circumstances described above. Given the apparent pervasiveness of this belief, §56.100 is adopted with a delayed effective date of January 2026, to provide time for industry to move toward compliance and allow the Texas Legislature to consider this issue during the 89th legislative session.

Other Changes Concerning Licensing (Subchapter B)

The adopted rules: in §56.102, Fees, clarify that the license fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS), and clarify that an insufficient funds fee under Finance Code §156.203(e) may be charged if the mortgage company makes a payment to SML by automated clearing house and that payment fails; in §56.103, Renewal of the License, clarify that a license approved with a pending deficiency is a conditional license and requires the mortgage company to resolve the deficiency within 30 days after the date the license is approved, and clarify that, if a license is not renewed within the reinstatement period provided by Finance Code §156.2081, a person must apply for a new license; in §56.104, NMLS License Records; Notices Sent to the Mortgage Company, change the contact person in NMLS to whom notices are sent from the contact person under "Identifying Information" to the contact person designated as the "Primary Company Contact" under "Contact Employee"; in §56.105, Conditional License, clarify the terms and conditions under which a conditional license may be granted; in §56.106, Surrender of the License, clarify circumstances under which SML may not grant a request made by the mortgage company to surrender its license; in §56.107, Sponsorship of the Originator; Responsibility for Originator's Actions, provide that a mortgage company license will revert to inactive status if the mortgage company fails to maintain a sponsored individual residential mortgage loan originator; and, in §56.108, Qualified Individual, establish a requirement that the contact information for the Qualified Individual for the mortgage company must match the principal address of the mortgage company in NMLS.

Changes Concerning Books and Records (§56.204)

Pursuant to Finance Code §156.301(a), SML may conduct inspections (examinations) of a mortgage company or an individual residential mortgage loan originator (originator) sponsored by a mortgage company (sponsored originator) to determine compliance with the requirements of Chapter 156 and the rules adopted thereunder. Examinations include inspection of the mortgage company's or sponsored originator's "books, records, documents, operations, and facilities . . . and access to any documents required under rules adopted under [Chapter 156]" (Finance Code §156.301(a)). Pursuant to Finance Code

§156.301(b), SML, upon receipt of a signed, written complaint against a mortgage company "shall investigate the actions and records" of the mortgage company or its sponsored originator. Pursuant to Finance Code §156.301(e), the commission "by rule shall . . . determine the information and records to which [SML] may demand access during an inspection or an investigation." Pursuant to Finance Code §156.102(c), the commission may "adopt rules regarding books and records that a [mortgage company] is required to keep, including the location at which the books and records must be kept." Meanwhile, with respect to sponsored originators, pursuant to Finance Code §157.021(a), SML may conduct examinations of an originator to determine compliance with Chapter 157 and the Texas SAFE Act, or the rules adopted thereunder. Examinations include inspection of the originator's "books, records, documents, operations, and facilities" (Finance Code §157.021(a)). Pursuant to Finance Code §157.021(b), SML, upon receipt of a signed written complaint against an originator, "shall investigate the actions and records" of the originator. Pursuant to Finance Code §157.021(e), the commission "by rule shall . . . determine the information and records [of the originator] to which [SML] may demand access during an inspection or an investigation." Pursuant to Finance Code §157.02015(b), the commission "may adopt rules regarding books and records that [an originator] is required to keep, including the location at which the books and records must be kept." The adopted rules, in §56.204, Books and Records: clarify that a mortgage company must maintain books and records on behalf of its sponsored originators; expand preexisting requirements by establishing additional data points for the mortgage transaction log a mortgage company is required to maintain under existing rules; establish a requirement for a mortgage company to maintain books and records concerning home equity line of credit transactions; establish a requirement for a mortgage company to maintain records relating to home equity loans; establish a requirement for a mortgage company to maintain a loan processing and underwriting log to track loan processing and underwriting services the mortgage company provides; establish recordkeeping requirements for corrective action taken by the mortgage company under §56.304; and establish recordkeeping requirements for the handling of unclaimed funds of the consumer under §56.305. The records and information a mortgage company is required to maintain under §56.204 are required by other state and federal law or otherwise generated in the ordinary course of doing business. The adopted rules merely require that the mortgage company capture and maintain the records or information, including transposing certain information to the transaction logs required by the rule. Applicable state and federal law a mortgage company is required to comply with and that triggers the maintenance of the records and information includes, but is not limited to: Article XVI, Section 50, Texas Constitution; Finance Code Chapter 156; Finance Code Chapter 159; Finance Code Chapter 343; the federal Consumer Credit Protection Act, Truth in Lending Act (15 U.S.C. §1601 et seq.) and Regulation Z (12 C.F.R. §1026.1 et seq.); the federal Real Estate Settlement Procedures Act (12 U.S.C. §2601 et seq.) and Regulation X (12 C.F.R. §1024.1 et seq.); the federal Equal Credit Opportunity Act (15 U.S.C. §1691 et seq.) and Regulation B (12 C.F.R. §1002.1 et seq.); the federal Fair Credit Reporting Act (15 U.S.C. §1681 et seq.) and Regulation V (12 C.F.R. §1022.1 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §6801 et seq.), Regulation P (12 C.F.R. §1016.1 et seq.), and the Federal Trade Commission's (FTC) Privacy of Consumer Financial Information Rules (16 C.F.R. §313.1 et seq.); the FTC's Standards for Safeguarding Customer Information Rule (16 C.F.R. §314.1 et seq.); the federal Secure and Fair Enforcement for Mortgage Licensing Act (12 U.S.C. §5101 et seq.) and Regulation H (12 C.F.R. §1008.1 et seq.); and Regulation N (Mortgage Acts and Practices-Advertising (MAP Rule); 12 C.F.R. §1014.1 et seq.).

Changes Concerning Reportable Incidents (§56.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §56.210, Reportable Incidents, establish requirements for a mortgage company to report certain information to SML when the mortgage company experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage company's operations or its customers." SML asserts such information is necessary to facilitate SML's examination authority described in the Changes Concerning Books and Records (§56.204) section above. Under federal law, pursuant to the FTC's Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage company must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage company "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage company must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage company to maintain the information required to be reported to SML under §56.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies

the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §56.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §156.004(a) or §157.0021(a) be signed by the individual residential mortgage loan originator and the mortgage applicant, remove the requirement that a mortgage company make the disclosure on social media sites, and establish the requirement for a mortgage company to disclose its website address on all correspondence sent to the mortgage applicant; in §56.201, Conditional Pre-Qualification and Conditional Approval Letters, establish the requirement that a conditional pre-qualification letter or conditional approval letter be signed by an individual residential mortgage loan originator acting on behalf of the mortgage company; in §56.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that a mortgage company commits a violation if the mortgage company knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that a mortgage company commits a violation if the originator solicits a consumer on the federal do-not-call registry, clarify that a mortgage company commits a violation if the mortgage company issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that a mortgage company commits a violation if the mortgage company engages in business when its license is inactive; in §56.203, Advertising, establish the requirement for a mortgage company to state its website address when making an advertisement, and establish requirements for the use of team names by a mortgage company; in §56.205, Mortgage Call Reports, clarify the required components of the mortgage call report, and clarify that mortgage call reports must be complete and accurate when filed.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §56.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §56.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §56.303, Corrective Action, clarify when SML may direct a mortgage company to take corrective action, and creating requirements for refunds made to consumers; in §56.304, establish requirements concerning the mortgage company's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; in §56.310, Appeals, establish various deadlines by which a mortgage company or other person subject to an enforcement action must appeal; and, in §56.311, Hearings, clarify how hearing costs under Finance Code §156.209(f) are calculated.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules, including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §56.201(d), requiring a residential mortgage loan originator working for a mortgage company to sign a conditional pre-qualification letter or conditional approval letter, is unnecessarily burdensome on industry as it would require reprograming the loan origination systems used by mortgage companies and outweighs any public benefit derived from the rule. SML respectfully disagrees with the comment. A conditional pre-approval letter or conditional approval letter is used to document a mortgage applicant's purchasing power in the marketplace and is relied on by the mortgage applicant to make an offer on residential real property and execute a real estate sales contract. The contract typically requires the mortgage applicant to tender an option fee and earnest money of several thousand dollars. If the mortgage applicant fails to complete the purchase, that money is often forfeited. Most claims made on the recovery fund established pursuant to Finance Code Chapter 156, Subchapter F are as a result of improperly issued conditional pre-qualification and conditional approval letters. It is important to establish that a residential mortgage loan originator issued the letter as evidenced by his or her signature so that SML can properly evaluate claims made on the fund. SML notes that the form for the conditional pre-qualification letter and conditional approval letter (required by Finance Code §156.105) is unchanged from the preexisting rule and contemplates that a residential mortgage loan originator issue the letter. With respect to costs, SML notes that the rule does not require the use of loan origination systems. As such, costs associated with making changes to such systems as a result of the adopted rules are not directly related to the rules. TMBA commented that §56.107(a) should include provisions backdating the sponsorship of an originator in its employ to the time the request for sponsorship was made in the system. §56.107(a), among other things, requires that a mortgage company must not allow an originator to work on behalf of a mortgage company until that originator is officially sponsored of record by the mortgage company in NMLS, the licensing database system used by SML. SML respectfully disagrees with the comment. SML relies on NMLS to determine when an originator is properly sponsored. As stated in the rule, a mortgage company is responsible for violations of law committed by its sponsored originators. The backdating of sponsorship is not feasible in NMLS and would create uncertainty as to whether an originator is truly sponsored. Additionally, an originator who knows his or her sponsorship will be backdated may not be properly motivated to remedy deficiencies holding up approval of a sponsorship request in the system. TMBA commented that §56.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §56.210 requires a mortgage company to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's examination authority and is similar to preexisting rules requiring a mortgage company to compile and maintain certain information in order to facilitate the examination process. As in-

dicated in the proposal, a mortgage company, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §56.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage company may be asked to take to correct violations of law determined during an examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to help guide and facilitate corrective action so that industry is aware of SML's expectations.

SML received a comment from the Texas Land Developers Association (TLDA). TLDA's comment relates to §56.100, which clarifies the exemption from licensing requirements created by Finance Code §156.202(a-1), concerning seller-finance lenders. TLDA, among other things, commented that it disagrees with SML's evaluation of the costs associated with §56.100 and questioned the methodology of SML's analysis, insisting that SML underestimated the potential number of seller-finance lenders required to be licensed under Finance Code. SML respectfully disagrees with the comment. As stated in the proposal, the requirement to be licensed is imposed by the Finance Code, not §56.100. The proposal included an exhaustive analysis of the licensing requirements imposed by the Finance Code. This analysis was done based on publicly available data concerning the number of seller-finance lenders that is inherently difficult to discern. That analysis included cost estimates based on TLDA's own assertions as to the potential number of seller-finance lenders required to be licensed under the Finance Code. Although TLDA challenges SML's methodology and the conclusions it reached, TLDA fails to identify another source of publicly available information that it suggests SML should have relied on. As indicated in the proposal, §56.100 is adopted with a delayed implementation date of January 1, 2026, in order for industry to come into compliance with statutory requirements, and for the Legislature to potentially take up and consider this issue during the 89th Legislative Session.

TLDA included with its comment purported comments from eight individuals who appear to be consumers. The TLDA comment also included a comment from the Mayor of Los Indios, Texas, a small city (population 1,008 in the 2020 census) situated along the Texas/Mexico border in Cameron County. The commenters generally extol the importance of seller-finance lending in the mortgage industry and encourage the commission to take a position on the rules that would maintain access to seller-finance lending for those who might not qualify for traditional financing. SML recognizes the impact of the seller-finance industry in the residential mortgage loan market; however, SML must administer and enforce the licensing requirements of the Finance Code as enacted by the Texas Legislature.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§56.1 - 56.6

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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

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SUBCHAPTER B. LICENSING

7 TAC §56.100

Statutory Authority

The rule is adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.100 is also adopted under the authority of, and to implement, Finance Code §156.201 and §156.202.

The adopted rule affects the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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7 TAC §§56.101 - 56.108

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.101 and §56.102 are also adopted under the authority of, and to

implement, Finance Code: §156.203 and §156.208. §56.103 is also adopted under the authority of, and to implement, Finance Code: §§156.208, 156.2081, and 156.210. §56.104 is also adopted under the authority of, and to implement, Finance Code §156.211. §56.105 is also adopted under the authority of, and to implement, Finance Code §156.210. §56.107 is also adopted under the authority of, and to implement, Finance Code: §156.201(c) and §156.211. §56.108 is also adopted under the authority of, and to implement, Finance Code: §156.201(c).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§56.200 - 56.204, 56.206, 56.210

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.200 is also adopted under the authority of, and to implement, Finance Code §156.004. §56.201 is also adopted under the authority of, and to implement, Finance Code §156.105. §§56.202, 56.203, and 56.210 are also adopted under the authority of, and to implement, Finance Code §156.303(a)(2) and (3). §56.204 is also adopted under the authority of, and to implement, Finance Code: §156.102(c) and §156.301. §56.206 is also adopted under the authority of, and to implement, Finance Code §156.212.

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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7 TAC §56.205

Statutory Authority

The rule is adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §56.205 is also adopted under the authority of, and to implement, Finance Code §156.213.

The adopted rule affects the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§56.300 - 56.304, 56.310, 56.311

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §§56.300 - 56.304 are also adopted under the authority of, and to implement, Finance Code: §156.301 and §156.305. §56.310 is also adopted under the authority of, and to implement, Finance Code: §§156.209, 156.302, 156.303, and 156.406. §56.311 is also adopted under the authority of, and to implement, Finance Code §156.209.

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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CHAPTER 57. MORTGAGE BANKERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 57: §§57.1 - 57.6, 57.100 - 57.104, 57.106, 57.107, 57.200 - 57.207, 57.210, 57.300 - 57.304, 57.310, and 57.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6905). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Mortgage Banker Rules from Chapter 81 to Chapter 57

SML has determined it should reorganize its rules concerning mortgage bankers by relocating them to Chapter 57, a vacant chapter, and devoting such chapter exclusively to rules affecting mortgage bankers. The adopted rules effectuate these changes.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §57.2, Definitions, adopt new definitions for "control person," "E-Sign Act," "making a residential mortgage loan," "person," "SML," "State Examination System," "trigger lead," "UETA," "wrap lender," and "wrap mortgage loan," while eliminating definitions for "Commissioner's designee," and "Department"; in §57.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage banker is required to make; in §57.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage banker may be delivered and signed electronically; and, in §57.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Registration (Subchapter B)

The adopted rules: in §57.100, Registration Requirements, clarify when a mortgage banker registration is required; in §57.101, Applications for Registration, establish requirements for applying for a mortgage banker registration; in §57.102, Fees, clarify that the registration fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS); in §57.103, Renewal of the Registration, clarify the requirements to renew the registration, clarify that a registration approved with a pending deficiency requires the mortgage banker to resolve the deficiency within 30 days after the date the registration is approved, and clarify that, if a registration is not renewed within the reinstatement period provided by Finance Code §157.0062, a person must apply for a new registration; in §57.104, NMLS Records; Notices Sent to the Mortgage Banker, establish requirements for the mortgage banker to update its registration records in NMLS and establish requirements concerning how SML will contact the mortgage banker using such records; in §57.106, Surrender of the Registration, clarify circumstances under which SML may not grant a request made by a mortgage banker to surrender its registration; and, in §57.107, Sponsorship of the Originator; Responsibility for Originator's Actions, establish requirements for which a mortgage banker is responsible for the actions of the individual residential mortgage loan originators it allows to act on its behalf, and provide that a mortgage banker registration will revert to inactive status if the mortgage banker fails to maintain a sponsored individual residential mortgage loan originator.

Changes Concerning Books and Records (§57.204)

Pursuant to Finance Code §157.0022, SML "may request documentary and other evidence [~~from a mortgage banker~~] considered by [~~SML~~] as necessary to effectively evaluate [~~a consumer~~] complaint, including correspondence, loan documents, and disclosures . . . [~~and a~~] mortgage banker shall promptly provide any evidence requested by the commissioner." Meanwhile, with respect to originators sponsored by a mortgage banker, pursuant to Finance Code §157.021(a), the SML commissioner (commissioner) may conduct inspections (including examinations) of an originator to determine compliance with Chapter 157 and the Texas SAFE Act, or the rules of [~~SML~~] adopted thereunder. Inspections include inspection of the originator's "books, records, documents, operations, and facilities" (Finance Code §157.021(a)). Pursuant to Finance Code §157.021(b), the commissioner, upon receipt of a signed written complaint against an originator, "shall investigate the actions and records" of the originator. Pursuant to Finance Code §157.021(e), the commission "by rule shall . . . determine the information and records [~~of the originator~~] to which the commissioner may demand access during an inspection or an investigation." Pursuant to Finance Code §157.02015(b), the commission "may adopt rules regarding books and records that [~~an originator~~] is required to keep, including the location at which the books and records must be kept." The adopted rules, in §57.204, Books and Records: clarify that a mortgage banker must maintain books and records on behalf of the individual residential mortgage loan originators it sponsors; establish additional data points for the mortgage transaction log a mortgage banker is required to maintain under existing rules; establish a requirement for a mortgage banker to maintain books and records concerning home equity line of credit transactions it originates; establish a requirement for a mortgage banker to maintain certain additional records relating to home equity loans; establish a requirement for a mortgage banker to maintain a loan processing and underwriting log to track loan processing and underwriting services the mortgage banker provides; establish recordkeeping requirements for corrective action taken by the mortgage banker under adopted §57.304; and establish recordkeeping requirements for the handling of unclaimed funds of the consumer under adopted §57.305. Most of the records and information a mortgage banker is required to maintain under adopted §57.204 are required by other state and federal law or otherwise generated in the ordinary course

of doing business. The adopted rules merely require that the mortgage banker capture and maintain the records or information, including transposing certain information to the transaction logs required by the rule. Applicable state and federal law a mortgage banker is required to comply with and that triggers the maintenance of the records and information includes, but not limited to: Article XVI, Section 50, Texas Constitution; Finance Code Chapter 157; Finance Code Chapter 159; Finance Code Chapter 343; the federal Consumer Credit Protection Act, Truth in Lending Act (15 U.S.C. §1601 et seq.) and Regulation Z (12 C.F.R. §1026.1 et seq.); the federal Real Estate Settlement Procedures Act (12 U.S.C. §2601 et seq.) and Regulation X (12 C.F.R. §1024.1 et seq.); the federal Equal Credit Opportunity Act (15 U.S.C. §1691 et seq.) and Regulation B (12 C.F.R. §1002.1 et seq.); the federal Fair Credit Reporting Act (15 U.S.C. §1681 et seq.) and Regulation V (12 C.F.R. §1022.1 et seq.); the federal Gramm-Leach-Bliley Act (15 U.S.C. §6801 et seq.), Regulation P (12 C.F.R. §1016.1 et seq.), and the Federal Trade Commission's (FTC) Privacy of Consumer Financial Information Rules (16 C.F.R. §313.1 et seq.); the FTC's Standards for Safeguarding Customer Information Rule (16 C.F.R. §314.1 et seq.); the federal Secure and Fair Enforcement for Mortgage Licensing Act (12 U.S.C. §5101 et seq.) and Regulation H (12 C.F.R. §1008.1 et seq.); and Regulation N (Mortgage Acts and Practices-Advertising (MAP Rule); 12 C.F.R. §1014.1 et seq.).

Changes Concerning Reportable Incidents (§57.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §57.210, Reportable Incidents, establish requirements for a mortgage banker to report certain information to SML when the mortgage banker experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage banker's operations or its customers." SML asserts such information is necessary to facilitate SML's inspection/examination authority described in the Changes Concerning Books and Records (§57.204) section above. Under federal law, pursuant to the FTC's Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage banker must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage banker "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage banker must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage banker to maintain the information required to be reported to SML under adopted §57.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §57.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §157.0021(a) be signed by the individual residential mortgage loan originator and the mortgage applicant, remove the requirement that a mortgage banker make the disclosure on social media sites, and establish the requirement for a mortgage banker to disclose its website address on all correspondence sent to the mortgage applicant; in §57.201, Conditional Pre-Qualification and Conditional Approval Letters, establish the requirement that a conditional pre-qualification letter or conditional approval letter be signed by an individual residential mortgage loan originator acting on behalf of the mortgage banker; in §57.202, Fraudulent, Misleading, or Deceptive Practices and Improper Dealings, clarify that a mortgage banker commits a violation if the mortgage banker knowingly misrepresents the lien position of a residential mortgage loan, create requirements concerning the use of trigger leads, clarify that a mortgage banker commits a violation if the mortgage banker solicits a consumer on the federal do-not-call registry, clarify that a mortgage banker commits a violation if the mortgage banker issues a conditional pre-qualification letter or conditional approval letter that is inaccurate, erroneous, or negligently-issued, and clarify that a mortgage banker commits a violation if the mortgage banker engages in business when its registration is inactive; in §57.203, Advertising, establish the requirement for a mortgage banker to state its website address when making an advertisement, and establish requirements for the use of team names by a mortgage banker; in §57.205, Mortgage Call Reports, clarify the required components of the mortgage call report, and clarify that mortgage call reports must be complete and accurate when filed; and in §57.207, Periodic Statements, establish a require-

ment that the mortgage banker comply with the requirements of federal law under Regulation Z (12 C.F.R. §1026.41), governing periodic statements sent to the borrower.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §57.300, Examinations, provide that examinations are conducted using the State Examination System, and that SML may participate in, leverage, or accept an examination conducted by another state agency or regulatory authority; in §57.302, Confidentiality of Examination, Investigation, and Inspection Information, clarify the confidentiality of information arising from an examination, investigation, or inspection by SML; in §57.303, Corrective Action, clarify when SML may direct a mortgage banker to take corrective action, and creating requirements for refunds made to consumers; in §57.304, Unclaimed Funds, establish requirements concerning the mortgage banker's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; and, in §57.310, Appeals, establish various deadlines by which a mortgage banker or other person subject to an enforcement action must appeal.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §57.201(d), requiring a residential mortgage loan originator working for a mortgage banker to sign a conditional pre-qualification letter or conditional approval letter, is unnecessarily burdensome on industry as it would require reprograming the loan origination systems used by mortgage bankers and outweighs any public benefit derived from the rule. SML respectfully disagrees with the comment. A conditional pre-approval letter or conditional approval letter is used to document a mortgage applicant's purchasing power in the marketplace and is relied on by the mortgage applicant to make an offer on residential real property and execute a real estate sales contract. The contract typically requires the mortgage applicant to tender an option fee and earnest money of several thousand dollars. If the mortgage applicant fails to complete the purchase, that money is often forfeited. Most claims made on the recovery fund established pursuant to Finance Code Chapter 156, Subchapter F are as a result of improperly issued conditional pre-qualification and conditional approval letters. It is important to establish that a residential mortgage loan originator issued the letter as evidenced by his or her signature so that SML can properly evaluate claims made on the fund. SML notes that the form for the conditional pre-qualification letter and conditional approval letter (required by Finance Code §157.02012) is unchanged from the preexisting rule and contemplates that a residential mortgage loan originator issue the letter. With respect to costs, SML notes that the rule does not require the use of loan origination systems. As such, costs associated with making changes to such systems as a result of the adopted rules are not directly related to the rules. TMBA commented that §57.107(a) should include provisions backdating the sponsorship of a residential mortgage loan originator in its employ to the time the request for sponsorship was made in the system. §57.107(a), among other things, requires that a mortgage banker must not allow a residential mortgage loan originator to work on behalf of a mortgage banker until that residential mortgage loan originator is officially sponsored of record by the mortgage banker in NMLS, the licensing database system used by SML. SML respectfully disagrees with the comment. SML relies on NMLS to determine when a residential mortgage loan originator is properly sponsored. As stated in the rule, a mortgage banker is responsible for violations of law committed by its sponsored originators. The backdating of sponsorship is not feasible in NMLS and would create uncertainty as to whether a residential mortgage loan originator is truly sponsored. Additionally, a residential mortgage loan originator who knows his or her sponsorship might be backdated may not be properly motivated to remedy deficiencies holding up approval of a sponsorship request in the system. TMBA commented that §57.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §57.210 requires a mortgage banker to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's examination authority and is similar to preexisting rules requiring a mortgage banker to compile and maintain certain information in order to facilitate the examination process. As indicated in the proposal, a mortgage banker, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §57.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage banker may be asked to take to correct violations of law determined during an examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to guide and facilitate corrective action so that industry is aware of SML's expectations.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§57.1 - 57.6

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

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

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SUBCHAPTER B. REGISTRATION

7 TAC §§57.100 - 57.104, 57.106, 57.107

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.100 is also adopted under the authority of, and to implement, Finance Code §157.003. §§56.101 - 57.103 are also adopted under the authority of, and to implement, Finance Code §§157.006 - 157.0062. §57.104 is also adopted under the authority of, and to implement, Finance Code §157.005. §57.107 is also adopted under the authority of, and to implement, Finance Code §157.019.

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§57.200 - 57.204, 57.206, 57.207, 57.210

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.200 is also adopted under the authority of, and to implement, Finance Code §157.0021. §57.201 is also adopted under the authority of, and to implement, Finance Code §157.0023(b) and §157.02012. §§57.202, 57.203, 57.207, and 57.210 are also adopted under the authority of, and to implement, Finance Code §157.009. §57.204 is also adopted under the authority of, and to implement, Finance Code §157.02015(b). §57.206 is also adopted under the authority of, and to implement, Finance Code §157.003(6).

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

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7 TAC §57.205

Statutory Authority

The rule is adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §57.205 is also adopted under the authority of, and to implement, Finance Code §157.020.

The adopted rule affects the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

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

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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§57.300 - 57.304, 57.310, 57.311

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). §§57.300 - 57.304 are also adopted under the authority of, and to implement, Finance Code §§157.0022, 157.009(d), 157.021, and 157.0211. §57.310 is also adopted under the authority of, and to implement, Finance Code §157.003(e) and §157.009.

The adopted rules affect the statutes in Finance Code Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act.

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

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CHAPTER 58. RESIDENTIAL MORTGAGE LOAN SERVICERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 58: §§58.1 - 58.5, 58.100 - 58.104, 58.106, 58.107, 58.200, 58.207, 58.210, 58.301 - 58.304, 58.310 and 58.311. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6924). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 79, Residential Mortgage Loan Servicers, affect residential mortgage loan servicers (mortgage servicers) registered with SML under Finance Code Chapter 158, Residential Mortgage Loan Servicers.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Servicer Rules from Chapter 79 to Chapter 58

SML has determined it should reorganize its rules concerning mortgage servicers by relocating them to Chapter 58, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §58.2, Definitions, adopt new definitions for "control person," "dwelling," "E-Sign Act," "mortgage servicer," "mortgage servicer rights," "residential mortgage loan," "residential real estate," "SML," and UETA," while eliminating definitions for "Commissioner's designee," "Department," and "the Act"; in §58.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures a mortgage servicer is required to make; in §58.4, Electronic Delivery and Signature of Notices, clarify that any notice or disclosure made by a mortgage servicer may be delivered and signed electronically; and, in §58.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Changes Concerning Registration (Subchapter B)

The adopted rules: in §58.100, Registration Requirements, clarify when a mortgage servicer registration is required (including as it relates to master servicers); in §58.102, Fees, clarify that the registration fee charged by SML is exclusive of fees charged by the Nationwide Multistate Licensing System (NMLS); in §58.103, Renewal of Registration, clarify that a registration approved with a pending deficiency requires the mortgage servicer to resolve the deficiency within 30 days after the date the registration is approved, and clarify that, if registration is not renewed prior to its expiration, the person must apply for a new registration; in §55.104, NMLS Records; Notices Sent to the Mortgage Servicer, establish requirements for the mortgage servicer to update its registration records in NMLS and establish requirements concerning how SML will contact the mortgage servicer using such records; in §58.106, Surrender of the Registration, clarify circumstances under which SML may not a request made a mortgage servicer to surrender its registration; and, in §58.107, Surety Bond Requirement, establish a requirement to use an electronic surety bond, and establishing requirements governing the required amount of the surety bond.

Changes Concerning Reportable Incidents (§58.210)

The mortgage industry in recent years, like many other industries, has experienced increasing operational risks to cybersecurity posed by threat actors, including third-party service providers subject to such risks. SML has found that, in many instances, regulated persons do not self-report incidents that pose a threat to operations, and SML only learns of the incident through consumer complaints filed with SML, or through media reports, leaving SML in a poor position to mount a regulatory response. The adopted rules, in §58.210, Reportable Incidents, establish requirements for a mortgage servicer to report certain information to SML when the mortgage servicer experiences a "security event" or a "catastrophic event." A "security event" is defined by the rule to mean "an event resulting in unauthorized access to, or disruption or misuse of, an information system, information stored on such information system, or customer information held in physical form." A "catastrophic event" is defined by the rule to mean "an event, other than a security event, that is unforeseen and results in extraordinary levels of damage or disruption to operations." For an event to be reportable under the rule, it must present "a material risk, financial or otherwise, to a mortgage servicer's operations or its customers." SML asserts such information is necessary to facilitate SML's investigation authority described in Finance Code §158.102. Under federal law, pursuant to the Federal Trade Commission's (FTC) Standards for Safeguarding Customer Information rules (16 C.F.R. §314.1, et seq.), a mortgage servicer must "develop, implement, and maintain a comprehensive information security program" to safeguard customer information (16 C.F.R. §314.3(a)), and must, among other things: conduct periodic risk assessments of the information system; design and implement safeguards to control risks to the integrity of the information system (including data encryption and controlling access); regularly test or monitor the effectiveness of the safeguards; implement policies and procedures and internal controls to ensure personnel can execute the information security program; oversee service providers to ensure

compliance with the information security program; continuously evaluate and adjust the information security program; establish a written incident response plan designed to promptly respond to, and recover from, any security event materially affecting the confidentiality, integrity, or availability of customer information; and, in the event of a breach involving the information of 500 or more consumers, report certain information to the FTC concerning the nature and extent of the breach. Meanwhile, pursuant to Business and Commerce Code §521.052, a mortgage servicer "shall implement and maintain reasonable procedures, including taking any appropriate corrective action, to protect from unlawful use or disclosure any sensitive personal information collected or maintained by the business in the regular course of business." Pursuant to Business and Commerce Code §521.053(i), for a breach involving the information of 250 or more Texas consumers, a mortgage servicer must report certain information to the attorney general. Considering the foregoing, the existing requirements of state and federal law already require a mortgage servicer to maintain the information required to be reported to SML under adopted §58.210 in the event of a security event. Moreover, a report made to the FTC or to the attorney general described above generally satisfies the requirements of the rule, other than the requirement to provide a "root cause analysis" concerning the "results or findings of an audit or investigation to determine the origin or root cause of security event, identify strategic measures to effectively contain and limit the impact of a security event, and to prevent a future security event"; however, SML asserts that a root cause analysis is subsumed under the existing requirements of state and federal law related to security events, as described above, in order to meaningfully comply with such requirements.

Other Changes Concerning Duties and Responsibilities (Subchapter C)

The adopted rules: in §58.200, Required Disclosures, remove the requirement that the disclosure to consumers required by Finance Code §158.101 be included on all correspondence sent to the borrower, and, instead, establish a requirement to make the disclosure on the first notice sent to the borrower that notifies the borrower of the mortgage servicer's role in servicing the loan, and establish a requirement to include the disclosure on the mortgage servicer's website; and, in §58.207, Periodic Statements, establish a requirement that the mortgage servicer comply with the requirements of federal law under Regulation Z (12 C.F.R. §1026.41), governing periodic statements sent to the borrower.

Changes Concerning Supervision and Enforcement (Subchapter D)

The adopted rules: in §58.302, Confidentiality of Investigation Information, clarify the confidentiality of information arising from an investigation by SML; in §58.303, Corrective Action, clarify when SML may direct a mortgage servicer to take corrective action, and creating requirements for refunds made to consumers; in §58.304, Unclaimed Funds, establish requirements concerning the mortgage servicer's handling of unclaimed funds of the consumer, including requiring the maintenance of a log to track the handling of such funds; and, in §58.310, Appeals, establish various deadlines by which a mortgage servicer or other person subject to an enforcement action must file an appeal.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments.

SML received a comment from the Texas Mortgage Bankers Association (TMBA). TMBA commented that §58.210, concerning Reportable Incidents, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. §58.210 requires a mortgage servicer to report to SML when it is subject to certain catastrophic events or security incidents. The rule is an extension of SML's investigation authority. As indicated in the proposal, a mortgage servicer, in order to comply with federal law, is already required to compile the information that is reported to SML under the rule. TMBA commented that §58.303, concerning Corrective Action, is outside SML's statutory authority. SML respectfully disagrees with the comment. Statutory authority for the rule was recited in the commission's proposal. The rule lays out certain actions a mortgage servicer may be asked to take to correct violations of law determined during examination. As stated in the rule, corrective action is voluntary. SML sees great benefit in establishing protocols in rule to guide and facilitate corrective action so that industry is aware of SML's expectations.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§58.1 - 58.5

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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SUBCHAPTER B. REGISTRATION

7 TAC §§58.100 - 58.104, 58.106

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.100 is also adopted under the authority of, and to implement, Finance Code §158.051. §58.101 and

§58.102 are also adopted under the authority of, and to implement, Finance Code: §158.053 and §158.058. §58.103 is also adopted under the authority of, and to implement, Finance Code §158.058. §58.104 is also adopted under the authority of, and to implement, Finance Code §158.054.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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7 TAC §58.107

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.107 is also adopted under the authority of, and to implement, Finance Code §158.055.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§58.200, 58.207, 58.210

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §58.200 is also adopted under the authority of Finance Code §158.101.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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Iain A. Berry
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SUBCHAPTER D. SUPERVISION AND ENFORCEMENT

7 TAC §§58.301 - 58.304, 58.310, 58.311

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158. §§58.301 - 58.304 are also adopted under the authority of, and to implement, Finance Code §158.102 and §158.106. §58.310 is also adopted under the authority of, and to implement, Finance Code: §§158.058 - 158.060, 158.103, 158.105, and 158.106.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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Iain A. Berry
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CHAPTER 59. WRAP MORTGAGE LOANS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts new rules in 7 TAC Chapter 59: §§59.1 - 59.5, 59.100 - 59.102, 59.200, 59.201, 59.300 - 59.303, 59.400 - 59.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6932). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 78, Wrap Mortgage Loans, affect wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan, including servicers of a wrap mortgage loan under Finance Code Chapter 159, Wrap Mortgage Loan Financing.

Changes Concerning the Reorganization (Relocation) of Wrap Mortgage Loan Rules from Chapter 78 to Chapter 59

SML has determined it should reorganize its rules concerning wrap mortgage loans by relocating them to Chapter 59, a vacant chapter. The adopted rules effectuate this change.

Changes Concerning General Provisions (Subchapter A)

The adopted rules: in §59.2, Definitions, adopt a new definition for "SML," while eliminating a definition for "Department"; in §59.3, Formatting Requirements for Notices, adopt formatting requirements for the various disclosures required under Finance Code Chapter 159; in §59.4, Electronic Delivery and Signature of Notices, clarify that any required notice or disclosure may be delivered and signed electronically; and, in §59.5, Computation of Time, clarify how time periods measured in calendar days are computed.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§59.1 - 59.5

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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General Counsel
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SUBCHAPTER B. LENDER REQUIREMENTS AND RESPONSIBILITIES

7 TAC §§59.100 - 59.102

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.101 is also adopted under the authority of, and to implement, Finance Code: §159.101 and §159.102. §59.102 is also adopted under the authority of, and to implement, Finance Code §159.105.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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Iain A. Berry
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For further information, please call: (512) 475-1535

SUBCHAPTER C. BORROWER'S RIGHTS AND RESPONSIBILITIES

7 TAC §59.200, §59.201

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.201 is also adopted under the authority of, and to implement, Finance Code §159.202.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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SUBCHAPTER D. WRAP LENDER AND SERVICER REQUIREMENTS

7 TAC §§59.300 - 59.303

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §59.301 and §59.303 are also adopted under the authority of, and to implement, Finance Code §159.152. §59.302 is also adopted under the authority of, and to implement, Finance Code §159.151.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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SUBCHAPTER E. SUPERVISION AND ENFORCEMENT

7 TAC §§59.400 - 59.403

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159. §§59.401 - 59.403 are also adopted under the authority of, and to implement, Finance Code §159.252.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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CHAPTER 78. WRAP MORTGAGE LOANS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 78: §§78.1 - 78.3, 78.100 - 78.102, 78.200, 78.201, 78.300 - 78.303, and 78.400 - 78.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6941). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 78, Wrap Mortgage Loans, affect wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan, including servicers of a wrap mortgage loan under Finance Code Chapter 159, Wrap Mortgage Loan Financing.

Changes Concerning the Reorganization (Relocation) of Wrap Mortgage Loan Rules from Chapter 78 to Chapter 59

SML has determined it should reorganize its rules concerning wrap mortgage loans by relocating them to Chapter 59, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 78. In a related adoption published elsewhere in this issue of the *Texas Register*, SML adopts new rules in Chapter 59 affecting wrap mortgage lenders, borrowers, and any person who collects or receives a payment from a wrap borrower under the terms of a wrap mortgage loan. The new rules are patterned after the preexisting rules in Chapter 78.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§78.1 - 78.3

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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SUBCHAPTER B. LENDER REQUIREMENTS AND RESPONSIBILITIES

7 TAC §§78.100 - 78.102

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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Iain A. Berry
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SUBCHAPTER C. BORROWER'S RIGHTS AND RESPONSIBILITIES

7 TAC §78.200, §78.201

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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SUBCHAPTER D. WRAP LENDER AND SERVICER REQUIREMENTS

7 TAC §§78.300 - 78.303

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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SUBCHAPTER E. COMPLIANCE AND ENFORCEMENT

7 TAC §§78.400 - 78.403

Statutory Authority

The rules are adopted under the authority of Finance Code §159.108, authorizing the commission to adopt and enforce rules for the intent of or to ensure compliance with Finance Code Chapter 159.

The adopted rules affect the statutes in Finance Code Chapter 159, Wrap Mortgage Loan Financing.

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

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Iain A. Berry
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CHAPTER 79. RESIDENTIAL MORTGAGE LOAN SERVICERS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 78: §§78.1 - 78.3, 78.100 - 78.102, 78.200, 78.201, 78.300 - 78.303, and 78.400 - 78.403. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6943). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 79, Residential Mortgage Loan Servicers, affect residential mortgage loan servicers

(mortgage servicers) registered with SML under Finance Code Chapter 158, Residential Mortgage Loan Servicers.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Servicer Rules from Chapter 79 to Chapter 58

SML has determined it should reorganize its rules concerning mortgage servicers by relocating them to Chapter 58, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 79. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 59 affecting mortgage servicers that are patterned after the preexisting rules in Chapter 79.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. REGISTRATION

7 TAC §§79.1 - 79.5

Statutory Authority

The rules are adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rules affect the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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Iain A. Berry
General Counsel
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SUBCHAPTER B. COMPLAINTS AND INVESTIGATIONS

7 TAC §79.20

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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SUBCHAPTER C. HEARINGS AND APPEALS

7 TAC §79.30

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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SUBCHAPTER D. INTERPRETATIONS

7 TAC §79.40

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

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

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SUBCHAPTER E. SAVINGS CLAUSE

7 TAC §79.50

Statutory Authority

The rule is adopted under the authority of Finance Code §158.003, authorizing the commission to adopt rules necessary for the purposes of or to ensure compliance with Finance Code Chapter 158.

The adopted rule affects the statutes in Finance Code Chapter 158, the Residential Mortgage Loan Servicer Registration Act.

§79.50. Savings Clause.

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

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CHAPTER 80. RESIDENTIAL MORTGAGE LOAN COMPANIES

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 80: §§80.1 - 80.5, 81.100 - 80.102, 80.105 - 80.107, 80.200 - 80.206, and 80.300 - 80.302. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6945). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 80, Residential Mortgage Loan Companies, affect residential mortgage loan companies (mortgage companies) licensed by SML under Finance Code Chapter 156.

Changes Concerning the Reorganization (Relocation) of Mortgage Company Rules from Chapter 80 to Chapter 56

SML has determined it should reorganize its rules concerning mortgage companies by relocating them to Chapter 56, a vacant chapter. The adopted rules repeal all preexisting rules in Chapter 80. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 56 affecting mortgage companies that are patterned after the preexisting rules in Chapter 80.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§80.1 - 80.5

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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

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SUBCHAPTER B. LICENSING

7 TAC §§80.100 - 80.102, 80.105 - 80.107

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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

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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§80.200 - 80.206

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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

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SUBCHAPTER D. COMPLIANCE AND ENFORCEMENT

7 TAC §§80.300 - 80.302

Statutory Authority

The rules are adopted under the authority of Finance Code §156.102, authorizing the commission to adopt rules necessary for the intent of or to ensure compliance with Finance Code Chapter 156, and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act).

The adopted rules affect the statutes in Finance Code Chapter 156, the Residential Mortgage Loan Company Licensing and Registration Act.

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

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CHAPTER 81. MORTGAGE BANKERS AND RESIDENTIAL MORTGAGE LOAN ORIGINATORS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (SML), adopts the repeal of all preexisting rules in 7 TAC Chapter 81: §§81.1 - 81.5, 81.100 - 81.111, 81.200 - 81.206, and 81.300 - 81.302. The commission's proposal was published in the September 6, 2024, issue of the *Texas Register* (49 TexReg 6947). The rules are adopted without changes to the published text and will not be republished.

Explanation of and Justification for the Rules

The preexisting rules under 7 TAC Chapter 81, Mortgage Bankers and Residential Mortgage Loan Originators, affect mortgage bankers registered with SML and individual residential mortgage loan originators (originators) licensed by SML under Finance Code Chapter 157.

Changes Concerning the Reorganization (Relocation) of Mortgage Banker Rules from Chapter 81 to Chapter 57

SML has determined it should reorganize its rules concerning mortgage bankers by relocating them to Chapter 57, a vacant chapter, and devoting such chapter exclusively to rules affecting mortgage bankers. The adopted rules repeal all preexisting rules in Chapter 81 concerning mortgage bankers. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 57 affecting mortgage bankers that are patterned after the preexisting rules in Chapter 81.

Changes Concerning the Reorganization (Relocation) of Residential Mortgage Loan Originator Rules from Chapter 81 to Chapter 55

SML has determined it should reorganize its rules concerning originators by relocating them to Chapter 55, a vacant chapter, and devoting such chapter exclusively to rules affecting originators. The adopted rules repeal all preexisting rules in Chapter 81 concerning originators. In a related adoption published elsewhere in this issue of the *Texas Register,* SML adopts new rules in Chapter 55 affecting originators that are patterned after the preexisting rules in Chapter 81.

Summary of Public Comments

Publication of the commission's proposal recited a deadline of 30 days to receive public comments. No comments were received.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §§81.1 - 81.5

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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Iain A. Berry
General Counsel
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For further information, please call: (512) 475-1535

SUBCHAPTER B. LICENSING OF INDIVIDUAL ORIGINATORS

7 TAC §§81.100 - 81.111

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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Iain A. Berry
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SUBCHAPTER C. DUTIES AND RESPONSIBILITIES

7 TAC §§81.200 - 81.206

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

Filed with the Office of the Secretary of State on November 3, 2024.

TRD-202405301
Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
Effective date: November 23, 2024
Proposal publication date: September 6, 2024
For further information, please call: (512) 475-1535

SUBCHAPTER D. COMPLIANCE AND ENFORCEMENT

7 TAC §§81.300 - 81.302

Statutory Authority

The rules are adopted under the authority of Finance Code §157.0023, authorizing the commission to adopt rules necessary to implement or fulfill the purposes of Finance Code Chapter 157 and as required to carry out the intentions of the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (12 U.S.C. §5101 et seq.; federal SAFE Act). The rules are also adopted under the authority of Finance Code §180.004(b), authorizing the commission to adopt rules necessary to implement Finance Code Chapter 180 and as required to carry out the intentions of the federal SAFE Act.

The adopted rules affect the statutes in Finance Code: Chapter 157, the Mortgage Banker Registration and Residential Mortgage Loan Originator License Act; and Chapter 180, the Texas

Secure and Fair Enforcement for Mortgage Licensing Act of 2009.

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

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Iain A. Berry
General Counsel
Department of Savings and Mortgage Lending
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TITLE 16. ECONOMIC REGULATION

PART 9. TEXAS LOTTERY COMMISSION

CHAPTER 401. ADMINISTRATION OF STATE LOTTERY ACT

SUBCHAPTER B. LICENSING AND SALES AGENTS

16 TAC §401.158, §401.160

The Texas Lottery Commission (Commission) adopts amendments to 16 TAC §401.158 (Suspension or Revocation of License) and §401.160 (Standard Penalty Chart) without changes to the proposed text as published in the September 27, 2024, issue of the *Texas Register* (49 TexReg 7703). The purpose of the amendments is to reinforce the Commission's zero tolerance policy regarding a Texas Lottery sales agent (retailer) selling lottery tickets to a minor by requiring revocation of the retailer's license in all cases involving a violation of a law or Commission rule where the licensee intentionally or knowingly sells or offers to sell a lottery ticket to a person that the licensee knows is younger than 18 years of age. See Texas Government Code §466.3051(a) (Sale of Ticket to or Purchase of Ticket by Person Younger Than 18 Years of Age).

The Commission received one comment opposing the proposed amendments from the Texas Food & Fuel Association (TFFA), which represents the wholesale and retail levels of the food and petroleum industries in Texas and whose members own, operate, or supply more than 16,500 retail convenience stores in Texas.

COMMENT: While TFFA does not condone sales to minors, it asserts the proposed amendments are excessively punitive by mandating the automatic revocation of a retailer's license for a first violation. TFFA notes the proposed amendments eliminate the Commission's discretion to issue an alternative penalty or consider mitigating circumstances, including the history of the retailer. TFFA also asserts that, because the Sunset Advisory Commission's review of the Commission is still in progress, this rulemaking is premature and should be placed on hold until legislation is passed to continue the Commission's operations.

RESPONSE: The prohibition of lottery ticket sales to minors is vitally important to maintaining the public's trust and ensuring the integrity of the Texas Lottery. While the Commission appreciates TFFA's comments, it is important to send a strong message to lottery retailers that preventing sales to minors must be a top priority for them, and the Commission believes that its zero tolerance policy and license revocation for a first violation is an appropriate measure to accomplish that.

These amendments are adopted under Texas Government Code §466.015(b)(3), which requires the Commission to adopt rules governing the enforcement of prohibitions on the sale of tickets to or by an individual younger than 18 years of age, and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

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

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

TRD-202405159
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: November 18, 2024
Proposal publication date: September 27, 2024
For further information, please call: (512) 344-5392

CHAPTER 401. ADMINISTRATION OF STATE LOTTERY ACT

The Texas Lottery Commission (Commission) adopts the repeal of existing 16 TAC §401.315 ("Mega Millions"Draw Game Rule) and the new 16 TAC §401.315 ("Mega Millions"Draw Game Rule) without changes to the proposed text as published in the August 23, 2024, issue of the *Texas Register* (49 TexReg 6391). The rules will not be republished.

The purpose of the repeal and new rule is to conform the play of the Mega Millions game in Texas to game changes recently adopted by the Mega Millions Lotteries and the Multi-State Lottery Association (MUSL). These changes include (1) increasing the purchase price of a ticket from $2 to $5; (2) changing the game matrix from 5/70 plus 1/25 (selection of five numbers from a field of 70 numbers and then one number from a field of 25 numbers) to 5/70 plus 1/24 (selection of five numbers from a field of 70 numbers and then selection of one number from a field of 24 numbers); (3) removing Megaplier® and Just the Jackpot® features; (4) changing the play of the game to include a Multiplier automatically generated by the Lottery Gaming System (as defined in the new rule) as part of the cost of a Play, which will multiply the non-jackpot prizes by 2, 3, 4, 5 or 10 times; (5) revising certain game definitions and references; (6) updating grammar and/or sentence structure changes to provide clarity, including renaming the top prize as the Jackpot Prize instead of Grand Prize; and (7) adding that the Mega Millions Lotteries are removing the graduated percentage escalator for the thirty annual payment schedule. Mega Millions Lotteries will take responsibility for the schedule of prize payments for a thirty annual graduated payment schedule. The new Mega Millions game changes

are expected to be implemented on April 5, 2025, with the first drawing under the new rule expected to be on April 8, 2025. Accordingly, the current Mega Millions rule will remain in effect until the date the new rule is implemented, which currently is expected to be April 5, 2025.

The Commission is a member of MUSL and is authorized to conduct the Mega Millions game in Texas under the conditions of the Cross-Sell Agreement between MUSL and the Mega Millions Lotteries, MUSL rules, the laws of the State of Texas, this rule (16 TAC §401.315), and under such further instructions, directives, and procedures as the Commission executive director may issue in furtherance thereof. To be clear, the authority to participate in the Mega Millions game is provided to the Commission by MUSL through the Cross-Sell Agreement and the conduct and play of the Mega Millions game in Texas must conform to the MUSL Product Group's Mega Millions game rules.

The Commission received forty-two (42) written comments on the proposed repeal and new rule during the public comment period.

COMMENTS: All commenters were against the proposed price increase from $2 to $5 to play Mega Millions. Many commenters expressed that they would no longer play the Mega Millions game at the higher price. Several commented that raising the price causes the game to be out of reach for some players and causes others to spend more than they can afford, is not proportionate with the slight improvement of the odds and is greedy. Several also commented that they did not like losing the choice to "Megaply"or not, nor did they like losing the "Just the Jackpot"option. A few commenters also expressed that less people will play the game, resulting in less money for Texas public education.

RESPONSE: The Commission is authorized by the Cross-Sell Agreement between MUSL and the Mega Millions Lotteries to sell the Mega Millions game in Texas. In order to sell this lottery game, the Commission must adhere to the conditions of the Cross-Sell Agreement, as well as the MUSL rules regarding the Mega Millions game. The Mega Millions Lotteries control the management of the game, game changes and new game features. The Commission has no vote, choice, or input, on the cost of the Mega Millions game, the play of the game, or the odds of the game. The Commission only has a choice to sell Mega Millions lottery tickets in accordance with the Cross-Sell Agreement and MUSL rules, or to not participate in the game. In FY 2024, the sale of Mega Millions resulted in the Commission transferring $144,025,131.52 in revenue to the state. Whether the Jackpot prize is won in Texas or in another state, the proceeds from each ticket sold in Texas stay in Texas. Because of the significant revenue brought to the State with the Mega Millions game, the Commission intends to continue selling the Mega Millions game pursuant to the Cross-Sell Agreement and MUSL rules.

SUBCHAPTER D. LOTTERY GAME RULES

16 TAC §401.315

The repeal is adopted under Texas Government Code §466.015(c), which authorizes the Commission to adopt rules governing the operation of the lottery; §466.451, which authorizes the Commission to adopt rules relating to multijurisdiction lottery games; and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

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

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

TRD-202405167
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: April 5, 2025
Proposal publication date: August 23, 2024
For further information, please call: (512) 344-5324

16 TAC §401.315

The new rule is adopted under Texas Government Code §466.015(c), which authorizes the Commission to adopt rules governing the operation of the lottery; §466.451, which authorizes the Commission to adopt rules relating to multijurisdiction lottery games; and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

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

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

TRD-202405168
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: April 5, 2025
Proposal publication date: August 23, 2024
For further information, please call: (512) 344-5324

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 97. COMMUNICABLE DISEASES
SUBCHAPTER A. CONTROL OF COMMUNICABLE DISEASES

25 TAC §§97.3, 97.4, 97.6

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §97.3, concerning What Condition to Report and What Isolates to Report or Submit; §97.4, concerning When and How to Report a Condition or Isolate; and §97.6, concerning Reporting and Other Duties of Local Health Authorities and Regional Directors. The amendments to §§97.3, 97.4, and 97.6 are adopted without changes to the proposed text as published in the August 9, 2024,

issue of the *Texas Register* (49 TexReg 5907), and therefore will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments are necessary to comply with Texas Health and Safety Code Chapter 81, amended by Senate Bill 969, 87th Regular Session, 2021, and update the list of notifiable conditions in Texas.

The amendment to §97.3 adds melioidosis and *Cronobacter spp.* in infants as notifiable conditions in Texas.

The amendments to §97.4 and to §97.6 implement the revisions to Texas Health and Safety Code Chapter 81 by updating the acceptable methods of reporting notifiable conditions to electronic data transmission, telephone, or fax. Notifiable conditions reported by telephone must be followed-up with an electronic data transmission through an approved electronic means within 24 hours of the original notification. The amendments improve the ability of public health entities to plan and implement response and mitigation measures, enhance public surveillance and timely reporting, and increase the availability of public health data in Texas.

COMMENTS

The 31-day comment period ended Monday, September 9, 2024.

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

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, and Texas Health and Safety Code §1001.075, which authorize the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001; and Texas Health and Safety Code Chapter 81 (Communicable Disease Prevention and Control Act), which authorizes the Executive Commissioner to identify reportable diseases and prescribe the form and method for reporting.

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

Filed with the Office of the Secretary of State on October 31, 2024.

TRD-202405214
Cynthia Hernandez
General Counsel
Department of State Health Services
Effective date: January 1, 2025
Proposal publication date: August 9, 2024
For further information, please call: (512) 776-7676

CHAPTER 133. HOSPITAL LICENSING

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §133.101, concerning Inspection and Investigation Procedures; and §133.102, concerning Complaint Against Department of State Health Services Surveyor; new §§133.101, concerning Integrity of Inspections and Investigations; 133.102, concerning Inspections; 133.103, concerning Complaint Investigations; 133.104, concerning Notice; 133.105, concerning Professional Conduct; and 133.106, concerning Complaint Against an HHSC Representative; and amendments to §133.47, concerning Abuse and Neglect Issues; and §133.121, concerning Enforcement.

The repeal of §133.101 and §133.102, and new §§133.104, 133.105, and 133.106 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3106). These rules will not be republished.

New §§133.101, 133.102, and 133.103 and amended §133.47 and §133.121 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3106). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement House Bill (H.B.) 49, 88th Legislature, Regular Session, 2023. H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

The adoption is also necessary to update the inspection, complaint investigation, and enforcement procedures for general and special hospitals. These updates are necessary to hold hospitals accountable during the inspection and investigation processes and ensure hospitals provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for hospitals from the Department of State Health Services (DSHS) to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from four commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Hospital Association (THA), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: THA expressed appreciation for HHSC considering comments from the previous public comment period and incorporating some of the feedback THA and other stakeholders provided.

Response: HHSC acknowledges this comment.

Comment: CCHR recommended including 911 and the contact information for the federally mandated protection and advocacy system to the posting required by §133.47(c)(2) to eliminate the need for multiple postings. DRTx recommended the posting required by §133.47(c)(2) include the contact information for the federally mandated protection and advocacy system.

Response: HHSC declines to revise §133.47(c)(2) because this paragraph is specific to reporting allegations under HSC §161.132. HHSC notes this paragraph does not preclude a hospital from combining the signage with other required postings.

Comment: CCHR, DRTx, TMA commented on the timeframe requirements in §133.47(c)(3)(A) and §133.47(c)(3)(B).

Regarding §133.47(c)(3)(A), CCHR stated abuse and neglect allegations should be reported immediately because these allegations are criminal matters and time is of the essence. They also stated that in a busy hospital, it may be difficult to preserve a crime scene for an extended amount of time and patient safety and evidence collection and preservation should be top priorities.

Regarding §133.47(c)(3)(A), DRTx stated time is of the essence when reporting allegations of abuse or neglect and the ability to gather sufficient evidence is lessened as time passes. DRTx also stated that the report is the trigger to initiate protective actions for the alleged victim and secure the evidence and recommended that the timeframe for reporting be as soon as possible, but no later than one hour.

Regarding §133.47(c)(3)(B), CCHR recommended a 24-hour deadline for reporting illegal, unprofessional, or unethical conduct.

Regarding §133.47(c)(3)(B), DRTx expressed concern with the 48-hour deadline because the sooner a report is made, the sooner actions to protect the alleged victim and evidence collection can occur. DRTx recommended the report be made as soon as possible, but no later than 24 hours.

TMA stated the proposed amendments to §133.47(c)(3)(A) and (B) go beyond the scope of the summary of the proposed amendments HHSC listed for this section in the proposal preamble because they are substantive changes. TMA expressed concern about the time limits for reporting abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because these timeframes may not always be possible or practical. TMA further stated these timeframes may discourage physicians and providers from even looking for signs of abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because they may fear being held responsible for reporting under these timeframes or encourage overreporting. TMA recommended against HHSC adopting the proposed timeframes or any finite reporting limits and recommended HHSC revert to the "as soon as possible" language stated in HSC §161.132.

Response: HHSC revised §133.47(c)(3)(A) and (B) to remove the 24-hour and 48-hour timeframes. Hospitals must report allegations under these subparagraphs as soon as possible in accordance with HSC §161.132.

Comment: CCHR stated trainings under §133.47(c)(4) should be competency based and a trainee should be able to demonstrate understanding and competence in applying the material.

DRTx recommended trainings under §133.47(c)(4) be competency based. DRTx stated there should be physical evidence at the end of the training that the trainee understood and retained the information provided and the training should have a test to protect the trainer, the facility, and individuals receiving services. Further, DRTx recommended staff being allowed to take a test instead of re-taking the required 8-hour training if there are no recorded concerns about infractions over the past year.

Response: HHSC declines to revise §133.47(c)(4) because HSC §161.133(a) requires the facility to provide a minimum of 8-hours of annual in-service training to staff in identifying patient abuse or neglect and illegal, unprofessional, or unethical conduct by or in the facility.

Comment: CCHR and DRTx recommended that in §133.47(f)(1)(A) and (B), the reporter, alleged victim, and the alleged victim's LAR, if the alleged victim has an LAR, should be informed of any appeal process and the timeframe for submitting an appeal.

Response: HHSC declines to revise §133.47(f)(1)(A) and (B) because investigations under §133.47(b) do not provide an appeal process for a complainant or an alleged violator.

Comment: CCHR stated the complainant should be informed of any appeal timelines and procedures and opportunities to contact an ombudsman under §133.47(f)(2).

DRTx recommended a complainant should receive information about any appeal process and timeframes to submit an appeal request under §133.47(f)(2).

Response: HHSC declines to revise §133.47(f)(2) because investigations under §133.47(c) do not provide an appeal process for a complainant or an alleged violator.

Comment: DRTx recommended HHSC add language to §133.47(g)(4) to require HHSC to inform the complainant, in a timely manner, if HHSC decides not to investigate and of the final disposition of the allegation, including any referrals HHSC made.

Response: HHSC declines to revise §133.47(g)(4) because a complainant notification process is already included under 25 TAC §133.47(f).

Comment: THA stated there was a possible grammatical error or missing words in §133.101(a)(2) and suggested the paragraph instead state, "may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless it first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion."

Response: HHSC revised §133.101(a)(2) by adding "unless the hospital first informs HHSC" to clarify that a hospital must first inform HHSC and then obtain HHSC's written approval before beginning to record or listen to an internal HHSC discussion.

Comment: THA requested HHSC revise §133.101(b) to clarify that a hospital must only inform HHSC of audio-capturing recording devices that are not readily visible. THA stated security cameras are present in many locations in hospitals, particularly hallways and common areas, and that it is possible cameras may be present while HHSC staff are having discussions. THA noted cameras in common areas would be visible to anyone and likely do not capture audio and should not require disclosure by the hospital.

Response: HHSC declines to revise §133.101(b) because HHSC staff need enhanced privacy for internal discussion and this paragraph is necessary to protect HHSC staff from intentional or unintentional eavesdropping.

Comment: THA expressed concern about §133.102(f) and §133.103(h), which require a hospital to permit HHSC access to interview members of a hospital's governing body, personnel, and patients, including the opportunity to request written statements. THA stated members of hospital governing bodies are often community members not involved in the hospital's daily operations and subjecting them to interviews may deter community involvement in hospital boards. THA further stated that requesting written statements from personnel and governing body members could lead to disputes and potential enforcement actions if statements are not provided or deemed unsatisfactory. THA requested HHSC remove the provisions allowing

interviews with governing body members and the requirement for written statements to avoid potential adversarial situations if a hospital declines HHSC's request.

Response: HHSC declines to revise §133.102(f) and §133.103(h) because it is important for HHSC staff to have the opportunity to talk to and request statements from relevant individuals, including, at times, members of a hospital's governing body. HHSC notes these subsections do not require a written statement and only allows HHSC the opportunity to request one.

Comment: THA questioned whether HHSC disclosing information to law enforcement agencies as allowed by §133.102(k)(4) and §133.103(m)(4) is appropriate or legally permissible. However, THA noted the statutory language supported this exception. THA stated that the Health Insurance Portability and Accountability Act (HIPAA) provides limited exceptions for disclosures to law enforcement, typically requiring specific legal processes like search warrants or subpoenas. THA further stated that the proposed rule may not comply with HIPAA and HSC §181.004. THA requested HHSC remove §133.102(k)(4) and §133.103(m)(4) because THA does not believe it is appropriate for HHSC to have rules specifically permitting the disclosure of confidential information to a law enforcement agency. Alternatively, THA requested HHSC revise §133.102(k)(4) and §133.103(m)(4) to state "law enforcement agencies as otherwise authorized or required by law."

Response: HHSC revised §133.102(k)(4) and §133.103(m)(4) to add "as allowed by law" to the end of the paragraphs.

Comment: CCHR expressed support for the inclusion of language added by H.B. 49, 88th Regular Session, 2023 at §133.102(l) and §133.103(n). H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

Response: HHSC acknowledges this comment.

Comment: TMA stated that §133.102(l) and §133.103(n) tracked the governing statute except for §133.102(l)(6) and §133.103(n)(6). TMA further stated Texas Government Code Chapter 552 generally gives the public the right to access government information on request, so §133.102(l)(6) and §133.103(n)(6) would make all inspection and investigation information, other than certain personally identifying information, subject to public disclosure, which conflicts with HSC §241.051(e). TMA recommended that §133.102(l)(6) and §133.103(n)(6) be removed to properly align with HSC §241.051(e).

Response: HHSC declines to remove §133.102(l)(6) and §133.103(n)(6) as recommended because these paragraphs state that HHSC will follow the requirements of public information laws, which prohibit disclosure of information made confidential by other laws, such as HSC §241.051. These paragraphs do not authorize disclosure of any information contrary to those laws.

Comment: THA expressed concern with the posting requirements at §133.103(a)(2) because the requirements will take time for hospitals to implement and there is a possible conflict with an existing rule at 25 TAC §1.191, which also mandates signage to notify patients where they can file complaints. THA requested HHSC withdraw §133.103(a)(2), review the rule at 25 TAC §1.191 alongside proposed §133.103(a)(2), and propose a unified rule that avoids duplicative or conflicting signage mandates. Alternatively, THA proposed an extended implementation period of at least 12 months for hospitals to comply with the signage requirements and for HHSC to provide guidance on how to reconcile the two rules.

Response: HHSC declines to remove §133.103(a)(2) because HHSC does not enforce 25 TAC §1.191 regarding hospitals. Section 133.103(a)(2) applies to hospitals regulated by HHSC, and 25 TAC §1.191 applies to facilities regulated by DSHS.

Comment: CCHR stated it hoped complaints regarding abuse, neglect, or exploitation, including verbal, physical, and sexual abuse, are given top priority under §133.103(c).

Response: HHSC acknowledges this comment.

Comment: DRTx commented on §133.103(c) and stated the current prioritization system relates to regulatory allegations but should not be used for abuse, neglect, and exploitation allegations. DRTx stated prioritizing one type of allegation over another results in some allegations being routinely delayed, such as verbal abuse or neglect allegations. DRTx recommended prioritizing investigations based on the likelihood of preserving evidence that could be used in making a final determination of the allegation. DRTx proposed that if an allegation is new (as in those reported within 24 hours), the allegation should receive top priority, regardless of the specific type of allegation. DRTx further stated if an allegation was reported several days after the event, the investigation should begin within 48 hours. DRTX stated if an allegation was reported a week or more after the event, delaying the investigation is justified because of the likelihood that the evidence has been contaminated or lost.

Response: HHSC declines to revise §133.103(c) because HHSC complaint prioritization and investigation initiation and completion timeframes are internal HHSC policy. HHSC notes that it investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §133.47; and reports possible criminal acts to the appropriate law enforcement authorities in accordance with state law and HHSC policies. HHSC notes the HHSC Complaint & Incident Intake webpage contains information about the complaint intake process.

Comment: CCHR stated it assumed that §133.103(d) applies to a concurrent regulatory investigation after an allegation of abuse, neglect, or exploitation. CCHR noted Texas's unique statutory framework and stated that while coordination with the Centers for Medicare & Medicaid Services (CMS) may be desirable in certain cases, HHSC has the duty and funding to uphold laws, regardless of CMS involvement or funding. CCHR cited the HSC regarding electroconvulsive therapy (ECT) as an example and noted that CMS regulations on ECT do not fully align with Texas statutes. CCHR stated that despite state law and CMS regulations not fully aligning, HHSC must investigate violations of Texas law independent of CMS because of the potential for harm.

Response: HHSC declines to revise §133.103(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §133.103(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting

investigations as described in Chapter 133 and HHSC internal policies.

Comment: DRTx recommended HHSC revise §133.103(d) by adding language regarding HHSC's duty to complete regulatory investigations regardless of CMS authorization. DRTx stated that HHSC and other state agencies have the authority and receive state funding to complete their responsibilities for facility investigations and regulatory oversight. DRTx further stated it is the responsibility of the state regulatory agency to protect Texas's vulnerable citizens, and HHSC should investigate allegations meeting the definitions of abuse and neglect in Texas law, even if CMS does not authorize an investigation. DRTx expressed concern with HHSC referring investigations of complaints involving psychiatric facilities that HHSC chose not to investigate to the Joint Commission. DRTx stated the Joint Commission is an accrediting body and does not perform investigations of abuse or neglect consistent with Texas regulations. DRTX also stated CMS does not provide any information about any investigation, review, or action on such referrals. DRTx stated such referrals result in the allegations not being addressed by any investigatory entity.

Response: HHSC declines to revise §133.103(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §133.103(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations as described in 25 TAC Chapter 1, Subchapter Q, Chapter 133, and HHSC internal policies.

Comment: THA requested HHSC extend the timeframe for hospitals to submit a plan of correction (POC) under §133.104(b)(2) because THA stated the proposed 10 calendar day timeframe was too compressed to develop an extensive POC and implementation plan. THA suggested language that would lengthen the timeframe to 30 calendar days for deficiencies that did not affect patient health and safety and language to allow flexibility for HHSC to require a shorter timeframe, but no earlier than 10 calendar days, for more urgent issues affecting or potentially affecting patient health and safety.

Response: HHSC declines to revise §133.104(b)(2) because 10 calendar days after receipt of a statement of deficiencies (SOD) is sufficient time to provide HHSC with a POC. HHSC notes a hospital is made aware of the issues HHSC found and the potential citations at the exit conference so the hospital can begin working on correcting any issues even before receipt of the SOD.

Comment: TMA stated §133.105 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §133.105 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §133.105 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: THA expressed concern with §133.106 not including the details related to HHSC's internal procedures regarding complaints against an HHSC representative, currently found at §133.102. THA stated it is important for facilities to understand how HHSC handles complaints against surveyors or investigators, including clear expectations for HHSC's response timeframe. THA requested HHSC include procedural details in the final rule to ensure transparency and provide facilities with an opportunity to provide input. Additionally, THA suggested the rule include clear anti-retaliation language to protect hospitals or individuals filing complaints, and proposed language prohibiting retaliation by HHSC or HHSC representatives against hospitals or persons filing a complaint against an HHSC representative.

Response: HHSC declines to revise §133.106 as requested because the agency addresses complaints against HHSC representatives in accordance with its policies, which include requiring staff to perform their duties in a lawful, professional, and ethical manner.

Comment: THA expressed concern with §133.121(1)(P) and stated participation in Medicare is voluntary and should not be a criterion for licensing decisions or penalties. THA requested HHSC remove this paragraph because THA stated a hospital terminating the hospital's Medicare provider agreement should not jeopardize the hospital's licensure status or result in penalties.

Response: HHSC revised §133.121(1)(P) to clarify this subparagraph applies if CMS terminates the hospital's Medicare provider agreement.

Comment: THA expressed concern with §133.121(2)(B)(ii) because THA stated the category is overly broad and that it is not uncommon for providers to make unintentional billing errors that result in Medicare sanctions, and in those cases the provider repays any amounts owed and associated penalties and is free to continue participating in the Medicare program. Further, THA stated other regulatory infractions of Medicare Conditions of Participation may result in citations and sanctions and penalties that are inconsequential and do not justify denying a hospital license.

Response: HHSC declines to revise §133.121(2)(B)(ii) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: THA requested HHSC revise §133.121(2)(B)(iii) to state "federal or state tax liens that are unsatisfied after all avenues of dispute have been exhausted" because THA stated the category is overly broad and stated that the hospital may not have had the opportunity to dispute a lien and HHSC could deny the hospital's license for an unresolved lien for which a dispute is pending.

Response: HHSC declines to revise §133.121(2)(B)(iii) because unsatisfied federal or state tax liens could indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC remove or revise §133.121(2)(B)(iv) because THA stated this clause is overly broad because there is no threshold amount in controversy, it does not account for audit exceptions that are still being disputed, civil judgments may be taken for many reasons that would have no bearing on the fitness to operate a hospital, and final judgments could still be on appeal and therefore be technically unsatisfied. Alternatively, THA requested HHSC revise this clause to specify the specific types of judgments that could result in denial and account for final judgments that may be on appeal and suggested for the rule to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted."

Response: HHSC declines to remove or revise §133.121(2)(B)(iv) because this clause provides HHSC regulatory oversight and could also indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC revise §133.121(2)(B)(vi) to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted." THA stated this clause is overly broad because there is no threshold amount in controversy, and it does not account for audit exceptions that are still being disputed.

Response: HHSC declines to revise §133.121(2)(B)(vi) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: Regarding §133.121(4), CCHR stated a 30-day probation period in lieu of license denial, suspension, or revocation is not a sufficient deterrent to prevent future behavior that may warrant license denial, suspension, or revocation.

Response: HHSC declines to revise §133.121(4) because the language in this paragraph is consistent with HSC §241.053(f). In addition, HSC §241.053(g) provides for HHSC to suspend or revoke the license of a hospital that does not correct items that were in noncompliance or that does not comply with the applicable requirements within the applicable probation period.

HHSC made an editorial change to §133.47(b)(1) to add an end parenthesis after a rule title.

HHSC made an editorial change to §133.47(d) to change the colon to a period to ensure consistency with rule drafting guidelines.

HHSC revised §133.101(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services hospital rule at 26 TAC §511.111(a).

HHSC revised §133.102(e) by adding "video surveillance" to the list of items a hospital must permit HHSC to examine during any HHSC inspection. This change is made so that the list in §133.102(e) is consistent with §133.103(g), other HHSC rules in this rule project, and the list in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §133.102(l)(6) and §133.103(n)(6) to remove the word "request" because the laws are about public information laws and not public information request laws.

HHSC revised §133.103 to add new subsection (p), which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER C. OPERATIONAL REQUIREMENTS

25 TAC §133.47

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.47. Abuse and Neglect Issues.

(a) Reporting. Incidents of abuse, neglect, exploitation, or illegal, unethical or unprofessional conduct as those terms are defined in subsections (b) and (c) of this section shall be reported to the Texas Health and Human Services Commission (HHSC) as provided in subsections (b) and (c)(3) of this section.

(b) Abuse or neglect of a child, and abuse, neglect, or exploitation of an elderly or disabled person. The following definitions apply only to this subsection.

(1) Abuse or neglect of a child, as defined in §1.204(a) and (b) of this title (relating to Abuse, Neglect, or Exploitation Defined).

(2) Abuse, neglect, or exploitation of an elderly or disabled person, as defined in §1.204(a) - (c) of this title.

(c) Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section.

(1) Definitions. The following definitions are in accordance with Texas Health and Safety Code (HSC) §161.131 and apply only to this subsection.

(A) Abuse--

(i) Abuse (as the term is defined in United States Code Title 42 (42 USC) Chapter 114 (relating to Protection and Advocacy for Individuals with Mental Illness) is any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as:

(I) the rape or sexual assault of an individual with mental illness;

(II) the striking of an individual with mental illness;

(III) the use of excessive force when placing an individual with mental illness in bodily restraints; and

(IV) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with federal and state laws and regulations.

(ii) In accordance with HSC §161.132(j), abuse also includes coercive or restrictive actions that are illegal or not justified by the patient's condition and that are in response to the patient's request for discharge or refusal of medication, therapy or treatment.

(B) Illegal conduct--Illegal conduct (as the term is defined in HSC §161.131(4)) is conduct prohibited by law.

(C) Neglect--Neglect (as the term is defined in 42 USC §10801 et seq.) is a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

(D) Unethical conduct--Unethical conduct (as the term is defined in HSC §161.131(11)) is conduct prohibited by the ethical standards adopted by state or national professional organizations for their respective professions or by rules established by the state licensing agency for the respective profession.

(E) Unprofessional conduct--Unprofessional conduct (as the term is defined in HSC §161.131(12)) is conduct prohibited under rules adopted by the state licensing agency for the respective profession.

(2) Posting requirements. A hospital shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical, or unprofessional conduct in accordance with HSC §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the current toll-free telephone number for submitting a complaint to HHSC as specified on the HHSC website.

(3) Reporting responsibility.

(A) Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the hospital who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the hospital who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(a).

(B) Reporting illegal, unprofessional, or unethical conduct. An employee of or other person associated with a hospital, including a health care professional, who reasonably believes or who knows of information that would reasonably cause a person to believe that the hospital or an employee or health care professional associated with the hospital, has, is, or will be engaged in conduct that is or might be illegal, unprofessional, or unethical and that relates to the operation of the hospital or mental health or chemical dependency services provided in the hospital shall as soon as possible report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(b).

(4) Training requirements. A hospital that provides comprehensive medical rehabilitation, mental health, or substance use services shall annually provide as a condition of continued licensure a minimum of eight hours of in-service training designed to assist employees and health care professionals associated with the hospital in identifying patient abuse or neglect and illegal, unprofessional, or unethical conduct by or in the hospital and establish a means for monitoring compliance with the requirement.

(d) Investigations. A complaint under this subsection will be investigated or referred by HHSC as follows.

(1) Allegations under subsection (b) of this section will be investigated in accordance with §1.205 of this title (relating to Reports and Investigations) and §1.206 of this title (relating to Completion of Investigation).

(2) Allegations under subsection (c) of this section will be investigated in accordance with §133.103 of this chapter (relating to Complaint Investigations). Allegations concerning a health care professional's failure to report abuse and neglect or illegal, unprofessional, or unethical conduct will not be investigated by HHSC but will be referred to the individual's licensing board for appropriate disciplinary action.

(3) Allegations under both subsections (b) and (c) will be investigated in accordance with §1.205 and §1.206 of this title except as noted in paragraph (2) of this subsection concerning a health care professional's failure to report.

(e) Submission of complaints. A complaint made under this section may be submitted in writing or verbally to HHSC.

(f) Notification.

(1) For complaints under subsection (b) of this section, HHSC shall provide notification according to the following.

(A) HHSC shall notify the reporter, if known, in writing of the outcome of the completed investigation.

(B) HHSC shall notify the alleged victim, and the alleged victim's parent or guardian if a minor, in writing of the outcome of the completed investigation.

(2) For complaints under subsection (c) of this section, HHSC informs, in writing, the complainant who identifies themselves by name and address of the following:

(A) the receipt of the complaint;

(B) if the complainant's allegations are potential violations of this chapter warranting an investigation;

(C) whether the complaint will be investigated by HHSC;

(D) whether and to whom the complaint will be referred; and

(E) the findings of the complaint investigation.

(g) HHSC reporting and referral.

(1) Reporting health care professional to licensing board.

(A) In cases of abuse, neglect, or exploitation, as those terms are defined in subsection (b) of this section, by a licensed, certified, or registered health care professional, HHSC may forward a copy of the completed investigative report to the state agency that licenses, certifies, or registers the health care professional. Any information which might reveal the identity of the reporter or any other patients of the hospital must be blacked out or deidentified.

(B) A health care professional who fails to report abuse and neglect or illegal, unprofessional, or unethical conduct as required by subsection (c)(3) of this section may be referred by HHSC to the individual's licensing board for appropriate disciplinary action.

(2) Sexual exploitation reporting requirements. In addition to the reporting requirements described in subsection (c)(3) of this section, a mental health services provider must report suspected sexual exploitation in accordance with Texas Civil Practice and Remedies Code §81.006.

(3) Referral follow-up. HHSC shall request a report from each referral agency of the action taken by the agency six months after the referral.

(4) Referral of complaints. A complaint containing allegations which are not a violation of HSC Chapter 241 or this chapter will not be investigated by HHSC but shall be referred to law enforcement agencies or other agencies, as appropriate.

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

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SUBCHAPTER F. INSPECTION AND INVESTIGATION PROCEDURES

25 TAC §133.101, §133.102

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

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25 TAC §§133.101 - 133.106

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.101. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a hospital:

(1) may not record, listen to, or eavesdrop on any HHSC interview with hospital staff or patients that the hospital staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of hospital staff when HHSC has requested a private room or office or distanced themselves from hospital staff unless the hospital first informs HHSC and the hospital obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A hospital shall inform HHSC when security cameras or other existing recording devices in the hospital are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits hospital staff to be present, an interview or conversation for which hospital staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§133.102. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an inspection of each hospital prior to the issuance or renewal of a license.

(1) A hospital is not subject to additional annual licensing inspections subsequent to the issuance of the initial license while the hospital maintains:

(A) certification under Title XVIII of the Social Security Act, 42 United States Code (USC), §§1395 et seq.; or

(B) accreditation from The Joint Commission, the American Osteopathic Association, or other national accreditation organization for the offered services.

(2) HHSC may conduct an inspection of a hospital exempt from an annual licensing inspection under paragraph (1) of this subsection before issuing a renewal license to the hospital if the certification or accreditation body has not conducted an on-site inspection of the hospital in the preceding three years and HHSC determines that an inspection of the hospital by the certification or accreditation body is not scheduled within 60 days of the license expiration date.

(b) HHSC may conduct an unannounced, on-site inspection of a hospital at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a hospital's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the hospital.

(c) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its hospitals by HHSC.

(d) HHSC inspections to evaluate a hospital's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed hospital is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(e) A hospital shall cooperate with any HHSC inspection and shall permit HHSC to examine the hospital's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the hospital, unless prohibited by law.

(f) A hospital shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(g) A hospital shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the hospital, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(h) Upon entry, HHSC holds an entrance conference with the hospital's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the hospital representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the hospital representative to inform the hospital representative of any preliminary findings of the inspection, including possible health and safety concerns. The hospital may provide any final documentation regarding compliance during the exit conference.

(k) HHSC shall maintain the confidentiality of hospital records as applicable under state or federal law. Except as provided by subsection (l) of this section, all information and materials in the possession of or obtained or compiled by HHSC in connection with an inspection are confidential and not subject to disclosure under Texas Government Code Chapter 552 (relating to Public Information), and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the hospital;

(2) the hospital that is the subject of the enforcement action, or the hospital's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate hospital services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying and hospital-identifying information has been deleted.

(l) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the hospital's alleged violation, which must include the provisions of law the hospital is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the hospital;

(3) the pleadings in any administrative proceeding to impose a penalty against the hospital for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the hospital, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(m) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a hospital's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §241.051.

§133.103. Complaint Investigations.

(a) A hospital shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the hospital.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The hospital shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to a hospital may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate a hospital's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients. Complaint investigations may be coordinated with the federal Centers for Medicare

& Medicaid Services and its agents responsible for the inspection of hospitals to determine compliance with the Conditions of Participation under Title XVIII of the Social Security Act, (42 USC, §§1395 et seq.), so as to avoid duplicate investigations.

(e) HHSC may conduct an unannounced, on-site investigation of a hospital at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a hospital's compliance with any applicable statute or rule;

(2) a hospital's plan of correction;

(3) a hospital's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a hospital's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the hospital.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A hospital shall cooperate with any HHSC investigation and shall permit HHSC to examine the hospital's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the hospital, unless prohibited by law.

(h) A hospital shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) A hospital shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the hospital, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) Upon entry, the HHSC representative holds an entrance conference with the hospital's designated representative to explain the nature, scope, and estimated duration of the investigation.

(k) The HHSC representative holds an exit conference with the hospital representative to inform the hospital representative of any preliminary findings of the investigation. The hospital may provide any final documentation regarding compliance during the exit conference.

(l) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(m) HHSC shall maintain the confidentiality of hospital records as applicable under state or federal law. Except as provided by subsection (n) of this section , all information and materials in the possession of or obtained or compiled by HHSC in connection with an investigation are confidential and not subject to disclosure under Texas Government Code Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the hospital;

(2) the hospital that is the subject of the enforcement action, or the hospital's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate hospital services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying and hospital-identifying information has been deleted.

(n) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the hospital's alleged violation, which must include the provisions of law the hospital is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the hospital;

(3) the pleadings in any administrative proceeding to impose a penalty against the hospital for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the hospital, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(o) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a hospital's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code Section 241.051 (relating to Inspections).

(p) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

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

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SUBCHAPTER G. ENFORCEMENT

25 TAC §133.121

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §241.026, which requires HHSC to develop, establish, and enforce standards for the construction, maintenance, and operation of licensed hospitals.

§133.121. Enforcement.

Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(1) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of the Act or the rules adopted under this chapter. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for the following:

(A) failure to comply with any applicable provision of the Texas Health and Safety Code (HSC), including Chapters 241, 311, and 327;

(B) failure to comply with any provision of this chapter or any other applicable laws;

(C) the hospital, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a patient;

(D) the hospital, or any of its employees, materially altering any license issued by HHSC;

(E) failure to comply with minimum standards for licensure;

(F) failure to provide a complete license application;

(G) failure to comply with an order of the HHSC executive commissioner or another enforcement procedure under HSC Chapters 241, 311, or 327;

(H) a history of failure to comply with the applicable rules relating to patient environment, health, safety, and rights that reflect more than nominal noncompliance;

(I) the hospital aiding, committing, abetting, or permitting the commission of an illegal act;

(J) the hospital, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the hospital pursuant to HSC Chapter 241 and the provisions of this chapter;

(K) failure to comply with other state and federal laws affecting the health, safety, and rights of hospital patients;

(L) failure to timely pay an assessed administrative penalty as required by HHSC;

(M) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(N) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction;

(O) failure to comply with applicable requirements within a designated probation period; or

(P) if the hospital is participating under Title XVIII of the Social Security Act, 42 United States Code (USC), §1395 et seq, the Centers for Medicare & Medicaid Services terminating the hospital's Medicare provider agreement.

(2) Denial of a license. HHSC has jurisdiction to enforce violations of HSC Chapters 241, 311, and 327 and this chapter. HHSC may deny a license if the applicant:

(A) fails to provide timely and sufficient information required by HHSC that is directly related to the application; or

(B) has had the following actions taken against the applicant within the two-year period preceding the application:

(i) decertification or cancellation of its contract under the Medicare or Medicaid program in any state;

(ii) federal Medicare or state Medicaid sanctions or penalties;

(iii) unsatisfied federal or state tax liens;

(iv) unsatisfied final judgments;

(v) eviction involving any property or space used as a hospital in any state;

(vi) unresolved federal Medicare or state Medicaid audit exceptions;

(vii) denial, suspension, or revocation of a hospital license, a private psychiatric hospital license, or a license for any health care facility in any state; or

(viii) a court injunction prohibiting ownership or operation of a facility.

(3) Emergency suspension. Following notice and opportunity for hearing, the executive commissioner of HHSC or a person designated by the executive commissioner may issue an emergency order in relation to the operation of a hospital licensed under this chapter if the executive commissioner or the executive commissioner's designee determines that the hospital is violating this chapter, a rule adopted pursuant to this chapter, a special license provision, injunctive relief, an order of the executive commissioner or the executive commissioner's designee, or another enforcement procedure permitted under this chapter and the provision, rule, license provision, injunctive relief, order, or enforcement procedure relates to the health or safety of the hospital's patients.

(A) HHSC shall send written notice of the hearing and shall include within the notice the time and place of the hearing. The hearing must be held within 10 days after the date of the hospital's receipt of the notice.

(B) The hearing shall be held in accordance with HHSC's informal hearing rules.

(C) The order shall be effective on delivery to the hospital or at a later date specified in the order.

(4) Probation. In lieu of denying, suspending, or revoking the license, HHSC may place the hospital on probation for a period of not less than 30 days, if HHSC finds that the hospital is in repeated noncompliance with these rules or HSC Chapter 241, and the hospital's noncompliance does not endanger the public's health and safety.

(A) HHSC shall provide notice to the hospital of the probation and of the items of noncompliance not later than the 10th day before the probation period begins.

(B) During the probation period, the hospital shall correct the items of noncompliance and report the corrections to HHSC for approval.

(5) Administrative penalty. HHSC has jurisdiction to impose an administrative penalty against a hospital licensed or regulated under this chapter for violations of HSC Chapters 241, 311, and 327 and this chapter. The imposition of an administrative penalty shall be in accordance with the provisions of HSC §241.059, §241.060, and §327.008.

(6) Licensure of persons or entities with criminal backgrounds. HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a hospital. HHSC shall apply the requirements of Texas Occupations Code Chapter 53.

(A) HHSC is entitled under Texas Government Code Chapter 411 to obtain criminal history information maintained by the Texas Department of Public Safety, the Federal Bureau of Investigation, or any other law enforcement agency to investigate the eligibility of an applicant for an initial or renewal license and to investigate the continued eligibility of a licensee.

(B) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53.

(C) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a hospital:

(i) a misdemeanor violation of HSC Chapter 241;

(ii) a misdemeanor or felony involving moral turpitude;

(iii) a misdemeanor or felony relating to deceptive business practices;

(iv) a misdemeanor or felony of practicing any health-related profession without a required license;

(v) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(vi) a misdemeanor or felony under Texas Penal Code (TPC), Title 5, involving a patient, resident, or a client of any health care facility, a home and community support services agency or a health care professional; or

(vii) a misdemeanor or felony under the TPC:

(I) Title 4;

(II) Title 5;

(III) Title 7;

(IV) Title 8;

(V) Title 9;

(VI) Title 10; or

(VII) Title 11.

(7) Offenses listed in paragraph (6)(C) of this subsection are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign, or military jurisdictions that indicate an inability or tendency for the person or entity to own or operate a hospital.

(8) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(9) Notice. If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(10) Acceptance. Within 20 calendar days after receipt of the notice, the applicant or licensee may notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(11) Hearing request.

(A) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days of receipt of the notice of the proposed action described in paragraph (9) of this subsection. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(B) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001, and Title 1, Chapter 357, Subchapter I (relating to Hearings under the Administrative Procedure Act).

(12) No response to notice. If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving the notice of the proposed action, the case shall be set for a hearing.

(13) Notification of HHSC's final decision. HHSC shall send the licensee or applicant a copy of HHSC's decision for denial, suspension or revocation of a license or imposition of an administrative penalty by certified mail, which shall include the findings of fact and conclusions of law on which HHSC based its decision.

(14) Admission of new patients upon suspension or revocation. Upon HHSC's determination to suspend or revoke a license, the license holder may not admit new patients until HHSC reissues the license.

(15) Decision to suspend or revoke. When HHSC's decision to suspend or revoke a license is final, the licensee must immediately cease operation, unless the district court issues a stay of such action.

(16) Return of original license. Upon suspension, revocation or non-renewal of the license, the original license shall be returned to HHSC within 30 calendar days of HHSC's notification.

(17) Reapplication following denial or revocation.

(A) One year after HHSC's decision to deny or revoke, or the voluntary surrender of a license by a hospital while enforcement action is pending, a hospital may petition HHSC, in writing, for a license. Expiration of a license prior to HHSC's decision becoming final shall not affect the one-year waiting period required before a petition can be submitted.

(B) HHSC may allow a reapplication for licensure if there is proof that the reasons for the original action no longer exist.

(C) HHSC may deny reapplication for licensure if HHSC determines that:

(i) the reasons for the original action continues;

(ii) the petitioner has failed to offer sufficient proof that conditions have changed; or

(iii) the petitioner has demonstrated a repeated history of failure to provide patients a safe environment or has violated patient rights.

(D) If HHSC allows a reapplication for licensure, the petitioner shall be required to meet the requirements as described in §133.22 of this chapter (relating to Application and Issuance of Initial License).

(18) Expiration of a license during suspension. A hospital whose license expires during a suspension period may not reapply for license renewal until the end of the suspension period.

(19) Surrender of a license. In the event that enforcement, as defined in this subsection, is pending or reasonably imminent, the surrender of a hospital license shall not deprive HHSC of jurisdiction in regard to enforcement against the hospital.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

CHAPTER 135. AMBULATORY SURGICAL CENTERS

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §135.21, concerning Inspections; §135.24, concerning Enforcement; and §135.25, concerning Complaints; an amendment to §135.22, concerning Renewal of License; and new §135.61, concerning Integrity of Inspections and Investigations; §135.62, concerning Inspections; §135.63, concerning Complaint Investigations; §135.64, concerning Notice; §135.65, concerning Professional Conduct; §135.66, concerning Complaint Against an HHSC Representative; and §135.67, concerning Enforcement.

The repeal of §§135.21, 135.24, and 135.25; new §§135.64, 135.65, 135.66, and 135.67; and amended §135.22 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3115). These rules will not be republished.

New §§135.61, 135.62, and 135.63 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3115). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to update the inspection, complaint investigation, and enforcement procedures for ambulatory surgical centers (ASCs). These updates are necessary to hold ASCs accountable during the inspection and investigation processes and ensure ASCs provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for ASCs from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received a comment regarding the proposed rules from one commenter, the Texas Medical Association (TMA).

Comment: TMA stated §135.65 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §135.65 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §135.65 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

HHSC revised §135.61(a)(1) to connect paragraphs (1) and (2) paragraphs with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services rural hospital rule at 26 TAC §511.111(a).

HHSC revised §135.61(a)(2) to add "unless the ASC first informs HHSC." The change is made to clarify a facility must first inform HHSC and then obtain HHSC written approval before beginning to record or listen to an internal HHSC discussion. The change also increases consistency with other HHSC rules in this rule project.

HHSC revised §135.62(d) and §135.63(g) by adding "video surveillance" to the list of items an ASC must permit HHSC to examine during any HHSC inspection. This change is made to increase consistency with other HHSC rules in this rule project and language in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §135.63 to add new subsection (n), which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER A. OPERATING REQUIREMENTS FOR AMBULATORY SURGICAL CENTERS

25 TAC §§135.21, 135.24, 135.25

STATUTORY AUTHORITY

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

Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

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

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Karen Ray
Chief Counsel
Department of State Health Services
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25 TAC §135.22

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

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

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Karen Ray
Chief Counsel
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For further information, please call: (512) 834-4591

SUBCHAPTER D. INSPECTION, INVESTIGATION, AND ENFORCEMENT PROCEDURES

25 TAC §§135.61 - 135.67

STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §243.009, which requires HHSC to adopt rules for licensing of ASCs; and §243.010, which requires those rules to include minimum standards applicable to ASCs.

§135.61. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, an ambulatory surgical center's (ASC's) staff:

(1) may not record, listen to, or eavesdrop on any HHSC interview with ASC staff or patients that the ASC staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of ASC staff when HHSC has requested a private room or office or distanced themselves from ASC staff unless the ASC first informs HHSC and the ASC obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) An ASC shall inform HHSC when security cameras or other existing recording devices in the ASC are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits ASC staff to be present, an interview or conversation for which ASC staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§135.62. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an unannounced, on-site inspection of an ambulatory surgical center (ASC) at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) an ASC's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the ASC.

(b) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its ASCs by HHSC.

(c) HHSC inspections to evaluate an ASC's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed ASC is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(d) An ASC shall cooperate with any HHSC inspection and shall permit HHSC to examine the ASC's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the ASC, unless prohibited by law.

(e) An ASC shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(f) An ASC shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the ASC, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(g) HHSC shall maintain the confidentiality of ASC records as applicable under state and federal law.

(h) Upon entry, HHSC holds an entrance conference with the ASC's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the ASC representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the ASC representative to inform the facility representative of any preliminary findings of the inspection, including any possible health and safety concerns. The ASC may provide any final documentation regarding compliance during the exit conference.

§135.63. Complaint Investigations.

(a) An ambulatory surgical center (ASC) shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the ASC.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The ASC shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate an ASC's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients.

(e) HHSC may conduct an unannounced, on-site investigation of an ASC at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) an ASC's compliance with any applicable statute or rule;

(2) an ASC's plan of correction;

(3) an ASC's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) an ASC's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the ASC.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its ASCs by HHSC.

(g) An ASC shall cooperate with any HHSC investigation and shall permit HHSC to examine the ASC's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the ASC, unless prohibited by law.

(h) An ASC shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) HHSC shall maintain the confidentiality of ASC records as applicable under state and federal law.

(j) An ASC shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the ASC, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(k) Upon entry, the HHSC representative holds an entrance conference with the ASC's designated representative to explain the nature, scope, and estimated duration of the investigation.

(l) The HHSC representative holds an exit conference with the ASC representative to inform the ASC representative of any preliminary findings of the investigation. The ASC may provide any final documentation regarding compliance during the exit conference.

(m) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(n) HHSC notifies complainants regarding the investigations outcome within 10 business days after completing the investigation.

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

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

CHAPTER 140. HEALTH PROFESSIONS REGULATION

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §140.433, concerning Licensing, Certifica-

tion, or Registration of Military Service Members, Military Veterans, and Military Spouses, and new §140.433, concerning Licensing, Certification, or Registration of Military Service Members, Military Spouses, and Military Veterans.

Repealed §140.433 and new §140.433 are adopted without changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5258). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement Senate Bill (S.B.) 422, 88th Legislature, Regular Session, 2023. S.B. 422, in part, amended Texas Occupations Code (TOC) Chapter 55 to update requirements for a state agency's recognition of a military service member's and military spouse's out-of-state professional license, which includes a licensed chemical dependency counselor (LCDC) license.

The adoption increases consistency between the adopted rule, the HHSC rules at 1 Texas Administrative Code (TAC) §351.3 and §351.6, and the statutory requirements regarding the licensing process for military service members, military spouses, and military veterans. The adoption also retains and updates certain language currently found in 25 TAC §140.433.

COMMENTS

The 31-day comment period ended August 19, 2024.

During this period, HHSC received one comment regarding the proposed rules from one individual commenter. A summary of the comment relating to the rules and HHSC's response follows.

Comment: An individual commenter requested HHSC revise new §140.433 to allow LCDCs holding a master's degree in counseling, psychology, or any related field to provide mental health services under their LCDC license. The stakeholder noted that LCDCs are currently allowed to supervise licensed social workers with a bachelor's degree who provide mental health services.

Response: HHSC declines to revise new §140.433 because the decision to authorize LCDCs to provide mental health services is determined by the Legislature, and HHSC does not have authority over this decision.

SUBCHAPTER I. LICENSED CHEMICAL DEPENDENCY COUNSELORS

25 TAC §140.433

STATUTORY AUTHORITY

The repeal is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Occupation Code Chapter 504, which authorizes the Executive Commissioner to adopt rules governing the performance, conduct, and ethics for persons licensed as LCDCs.

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

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 834-4591

25 TAC §140.433

STATUTORY AUTHORITY

The new section is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Occupation Code Chapter 504, which authorizes the Executive Commissioner to adopt rules governing the performance, conduct, and ethics for persons licensed as LCDCs.

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

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Karen Ray
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For further information, please call: (512) 834-4591

CHAPTER 157. EMERGENCY MEDICAL CARE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts amendments to §157.2, concerning Definitions; §157.125, concerning Requirements for Trauma Facility Designation Effective Through August 31, 2025; and §157.128, concerning Denial, Suspension, and Revocation of Trauma Facility Designation; the repeal of §157.123, concerning Regional Emergency Medical Services/Trauma Systems; §157.130, concerning Emergency Medical Services and Trauma Care System Account and Emergency Medical Services, Trauma Facilities, and Trauma Care System Fund; and §157.131, concerning Designated Trauma Facility and Emergency Medical Services Account; and new §157.123, concerning Regional Advisory Councils; §157.126, concerning Trauma Facility Designation Requirements Effective on September 1, 2025; and §157.130, concerning Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Medical Services Account.

Sections 157.2, 157.123, 157.125, 157.126, and 157.130 are adopted with changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5648) and these rules will be republished.

The amendment of §157.128 and the repeals of §§157.123, 157.130 and 157.131 are adopted without changes to the proposed text as published in the August 2, 2024, issue of the *Texas Register* (49 TexReg 5648) and the rules will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments, repeal, and new sections update the content and processes with the advances, evidence-based practices, and system processes that have developed since these rules were adopted and to align with American College of Surgeons (ACS) standards. The rules also require amendments to implement legislation passed since the rules were last adopted. Senate Bill (S.B.) 330, 79th Legislature, Regular Session, 2005, amends Texas Health and Safety Code §773.203, requiring the development of regional stroke plans. House Bill (H.B.) 15, 83rd Legislature, Regular Session, 2013, and H.B. 3433, 84th Legislature, Regular Session, 2015, amend Texas Health and Safety Code §241.183, requiring the development of perinatal care regions. S.B. 984, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §81.027, directing the Regional Advisory Councils (RACs) to collect specific health care data. S.B. 969, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §81.0445, requiring the RACs to provide public information regarding public health disasters to stakeholders. S.B. 1397, 87th Legislature, Regular Session, 2021, amends Texas Health and Safety Code §773.1141, requiring a RAC with at least one county located on the international border of Texas and at least one county adjacent to the Gulf of Mexico to track all patient transfers and the reasons for the transfers out of its region.

A workgroup was formed to collaborate with DSHS staff to review the public comments received and determine the most appropriate language to ensure the health and safety of trauma patients and prevent any undue burden on the facilities providing trauma care. The workgroup composition included representatives from the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC), GETAC Trauma Systems Committee, Regional Advisory Councils (RACs), Texas Hospital Association (THA), Texas Organization of Rural and Community Hospitals (TORCH), and Texas Medical Association (TMA) with diverse backgrounds and geographic locations.

COMMENTS

The 31-day comment period ended September 3, 2024.

During this period, DSHS received comments regarding the proposed rules from 66 commenters, including Baptist Hospital of Southeast Texas; Border Regional Advisory Council; Capital Area of Texas Regional Advisory Council (CATRAC); Children's Hospitals Association of Texas (CHAT); Golden Plains Community Hospital; Harris Health; Southeast Texas Regional Advisory Council (SETRAC); Teaching Hospitals of Texas (THOT); Texas College of Emergency Physicians (TCEP); Texas EMS, Trauma and Acute Care Foundation (TETAF); Emergency Medical Services for Children State Partnership, Texas; Texas Health Resources (THR); Texas Hospital Association (THA); Texas Medical Association (TMA); United Regional Health Care (UHRC) System; The University of Texas Medical Branch (UTMB); and 50 individual commenters. A summary of comments relating to Chapter 157 and DSHS's responses follow.

Comment: One commenter supports not increasing the financial burden for Level IV trauma facilities.

Response: DSHS appreciates the comment. No change is necessary to the rules.

Comment: One commenter recommended revising the definition of "Abandonment" in §157.2(1) because a patient released from a hospital to EMS personnel would be considered an individual of lesser education.

Response: DSHS disagrees and declines to revise the language. EMS personnel work under the direction of a physician EMS Medical Director.

Comment: Several commenters recommended adding "or a department-approved survey organization" to the Level IV hospital with 100 or less trauma patients in §157.2(20) Basic Level IV trauma facility.

Response: DSHS agrees and adds "or a department-approved survey organization."

Comment: Multiple commenters recommended revising the language "evaluate and admit" for the Level IV trauma facility in §157.2(20), §157.126(g)(4)(A) and (B), (h)(8), (h)(19) - (21), (h)(25), (h)(30) - (32), (n), (n)(3) - (4), (o)(3), and (o)(3)(A) - (B).

Response: DSHS agrees and replaces "evaluating and admitting" with "managing" and included changes to §157.125(t) replacing "evaluated" with "managed," (x)(3)(D) replacing "evaluated and admitted" with "managed," and (y)(4)(D) replacing "evaluated and admitted" with "managed by," for consistent language in the rule.

Comment: Two commenters recommended revising the definition of "Bypass" in §157.2(23) by removing the last sentence: "Bypass protocols must have local physician input…be reviewed through the regional performance improvement process."

Response: DSHS acknowledges the comment and revises the definition to "Direction given to prehospital emergency medical services personnel by direct on-line medical control, or off-line medical director protocols to bypass the nearest facility for the most appropriate facility."

Comment: Two commenters recommended replacing "completed within 14 days" with "in process within 14 days" in §157.2(31), Concurrent performance improvement.

Response: DSHS disagrees and declines to revise the language, which would allow unlimited time to complete the review.

Comment: One commenter recommended adding language to clarify the administrator's duties in §157.2(44), Designated facility administrator.

Response: DSHS disagrees and declines to change the language. The language is sufficient.

Comment: Two commenters recommended listing out all designation programs in §157.2(46), Designation.

Response: DSHS disagrees and declines to add the language. The language is inclusive and applies to all types of designation.

Comment: Two commenters recommended less descriptive language in §157.2(51), Diversion.

Response: DSHS disagrees and declines to modify the language. The language is sufficient.

Comment: One commenter recommended adding "saturation" to §157.2(51), Diversion.

Response: DSHS disagrees and declines to add the language. The term "diversion" is aligned with the American College of Surgeons (ACS) and the Emergency Medical Treatment and Active Labor Act (EMTALA).

Comment: One commenter recommended having emergency medicine physicians added to the definition in §157.2(57), Emergency medical services personnel.

Response: DSHS declines to add the language. Legislation is required to add personnel as this aligns with the statute.

Comment: One commenter recommended replacing the term "person" with "an agency" in §157.2(58), Emergency medical services provider.

Response: DSHS acknowledges the comment and replaces "a person" with "an organization that" and revises 157.2(82) language to be consistent.

Comment: Two commenters recommended replacing "trauma" with "emergency health" care systems in §157.2(68), Extraordinary emergency.

Response: DSHS disagrees and declines to modify the language because it aligns with language in Chapter 773.

Comment: One commenter recommended revising the language to reflect working with multiple EMS providers in §157.2(71), First responder organization (FRO).

Response: DSHS agrees and revises the language to "licensed EMS providers."

Comment: Multiple commenters recommended that §157.2(77), "Injury severity score;" §157.2(84), "Major trauma patient;" and §157.2(122), "Severe trauma patient" align with the Association for the Advancement of Automotive Medicine (AAAM) scoring system.

Response: DSHS acknowledges and removes ISS language and specific scores from the definitions with injury descriptions, including §157.2(41), Critically injured person, because the ACS and AAAM scoring descriptions are different.

Comment: Two commenters requested clarification on why the level of harm is a requirement in §157.2(80), Level of harm and suggest revising to "should."

Response: DSHS disagrees and declines to revise the language. The level of harm assists trauma personnel in defining the urgency of review by the program. It is common terminology used by hospitals and medical providers.

Comment: One commenter recommended revising §157.2(82), Licensee, to be specific for a licensed paramedic.

Response: DSHS disagrees with the recommendation and declines to revise the language.

Comment: Two commenters recommended that the rural county population be changed to 68,570 to align with Medicaid in §157.2(119), Rural county.

Response: DSHS declines to modify the language. The county population for a rural area is specified in Texas Health and Safety Code §773.0045 as 50,000.

Comment: Two commenters recommended revising "housed within the department" to "provided by the department" in §157.2(130), State Trauma Registry.

Response: DSHS acknowledges and revises "housed within the department" to "managed by the department."

Comment: Two commenters recommended changing "transferring, or providing," to "transferring, and providing" in §157.2(133), Stroke facility.

Response: DSHS disagrees and declines to revise the language. The use of "or" in the language allows options for the stroke services provided by a stroke facility based on the available resources.

Comment: One commenter recommended using one term throughout the rule language for §157.2(142), Trauma and emergency health care system plan.

Response: DSHS acknowledges and replaces "EMS/trauma" with "trauma and emergency health care system plan" in §157.2(115), Regional medical control; replaces "RAC system plan development" with "development of the regional trauma and emergency health care system plan" in paragraph (145), Trauma facility; revises "system plan development" to "the development of the regional trauma and emergency health care system plan" in paragraph (146), Trauma medical director (TMD); adds "trauma and emergency health care" in §157.123(c)(1); adds "emergency" in §157.123(e)(2)(C); and adds "trauma and emergency health care" in §157.125(h)(1).

Comment: Several commenters recommended requiring trauma medical director (TMD) participation in the RAC by aligning §157.126(b)(5) language with §157.2(146). The TMD participation in the RAC is essential to providing guidance in patient distribution during surges, emergency preparedness, transfers, and medical care.

Response: DSHS agrees and revises the language to require TMD participation in the RAC. The RACs are required to provide a virtual option for meeting attendance to facilitate TMD participation.

Comment: One commenter recommended to remove TMD participation in the RAC from the definition §157.2(146) Trauma medical director, because it is too burdensome.

Response: DSHS acknowledges and adds "or designee" allowing the TMD to appoint an individual to participate in the RAC when they are unable to attend.

Comment: One commenter supported pediatric readiness in the RAC trauma and emergency health care system plan as required in §157.123(c)(1)(I).

Response: DSHS appreciates the comment and no revisions are made in response to this comment.

Comment: Two commenters recommended the following revisions in §157.123(d): (1) require data collection only during a declared disaster and when funded by the department; (2) remove the reporting requirements; (3) the executive commissioner to identify when and what information will be reported; and (4) for the RAC website to have a DSHS link to the data.

Response: DSHS disagrees and declines to revise the language in §157.123(d) as recommended. However, DSHS revises the language reducing the frequency and volume of data collection and reporting to the department to avoid duplication with new federal reporting requirements.

Comment: Two commenters recommended deleting the requirement or deleting the reference to subsections (a) and (b) in §157.123(f)(1) because it is in RAC contracts.

Response: DSHS disagrees and declines to delete the language. The department is required by Texas Health and Safety Code Chapter 773 to develop performance measures for the RACs.

Comment: Two commenters recommended deleting subsections (a) and (b) in §157.123(f)(3) and deleting the regional trauma and emergency health care system plan in §157.123(f)(3) and §157.130(a)(5)(B)(ii).

Response: DSHS disagrees and declines to delete the language. The department is required by Texas Health and Safety Code Chapter 773 to develop performance measures for the RACs.

Comment: Two commenters recommended revising language in §157.123(i) to replace "must maintain virtual options" with "should maintain virtual options."

Response: DSHS disagrees and declines to revise the language. Participation by all health care personnel in the RAC is essential. The virtual option allows health care personnel to participate when they cannot attend in person.

Comment: Several commenters recommended aligning the neurosurgeon or advanced practice provider (APP) response with the ACS standards in §157.125(x)(17) - (18).

Response: DSHS agrees and modifies the language to "and neurosurgical evaluation must occur within 30 minutes for the following criteria: severe traumatic brain injury (TBI) with a Glasgow coma scale (GCS) less than 9 and computed tomography (CT) evidence of TBI; moderate TBI with GCS of 9-12 and CT evidence of potential intracranial lesions; and neurological deficit produced by a potential spinal cord injury. When a neurosurgical APP or neurosurgical resident is utilized, there must be documented evidence of consultation with the neurosurgical attending on-call prior to implementation of the plan of care. This must be continuously monitored by the trauma PIPS program, including the consult times and response times."

Comment: Two commenters recommended removing advanced trauma life support (ATLS) requirement for APPs or adding a department-approved equivalent for ATLS in §157.125(x)(31)(C)(i).

Response: DSHS acknowledges the comments and revises the language in (x)(31)(C), specifying APPs who participate in trauma patient resuscitations must maintain current ATLS which aligns with the ACS 2022 standards. The department-approved equivalent language is included if a comparable course is proposed to meet the requirement.

Comment: Two commenters recommended adding a 90-day deadline for the department to complete and notify the facility of a designation determination in §157.126(c).

Response: DSHS disagrees and declines to modify the language. The rule language is sufficient.

Comment: Two commenters recommended removing "trauma patient care" in §157.126(d)(3)(C) because it is not defined in §157.2, Definitions, for a non-contiguous emergency department.

Response: DSHS disagrees and declines to revise because the rule language is sufficient.

Comment: One commenter recommended a language revision to include trauma patients managed at a facility's remote emergency department in the facility's main campus trauma registry in §157.126(d)(3)(C).

Response: DSHS acknowledges and declines to revise the language. The language is sufficient.

Comment: Two commenters recommended only having one Basic trauma facility designation (Level IV) description in §157.126(g)(4)(A) - (B).

Response: DSHS disagrees and declines to modify the language. The rule language separated by trauma patient volume is necessary to address the considerable variances in the capabilities and resources of the facilities designated at this level. The four levels of trauma designation align with the ACS standards and other designation programs.

Comment: Two commenters recommended replacing National Trauma Data Bank (NTDB) with National Trauma Data Standard (NTDS) in §157.126(g)(4)(B) and (h)(21).

Response: DSHS disagrees and declines to modify the language. The language is sufficient.

Comment: One commenter recommended adding the current year for NTDS definitions in §157.126(h)(2). The commenter is concerned that the State Trauma Registry runs behind the current year of data.

Response: DSHS declines to add the language. This recommendation would need to be addressed in the state trauma registry rules.

Comment: Two commenters recommended removing the EMS wristband number in §157.126(h)(4).

Response: DSHS disagrees and declines to remove the language. The language is sufficient and includes measures for patient tracking.

Comment: Two commenters recommended removing EMS hand-off language in §157.126(h)(5).

Response: DSHS disagrees and declines to remove the language. Effective communication between EMS personnel and the trauma team is essential when transferring patient care.

Comment: Two commenters recommended removing the §157.126(h)(8)(E) management guidelines for trauma due to abuse.

Response: DSHS disagrees and declines to delete the language. Stakeholders requested this language be included while developing the new rule language.

Comment: Multiple commenters support the Pediatric Readiness requirements in §157.126(h)(12) and (h)(12)(A) -(G).

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: Two commenters recommended revising the language requiring "a written plan of correction addressing identified opportunities in pediatric readiness" in §157.126(h)(12)(A), to "monitoring the results in the Trauma Performance Improvement and Patient Safety (PIPS) plan."

Response: DSHS disagrees and declines to revise the language. The trauma performance improvement (PI) process includes a written plan of correction to address and resolve the identified opportunities.

Comment: One commenter recommended defining "staff" and a threshold for how often the competence should be evaluated in requirement §157.126(h)(12)(B).

Response: DSHS disagrees and declines to modify the language. The language is sufficient and to be defined by the facility.

Comment: One commenter recommended removing §157.126(h)(12)(F) regarding pediatric imaging guidelines addressing pediatric age or weight-based dosing.

Response: DSHS disagrees and declines to remove or revise the language. The language is sufficient and multiple commenters support the new pediatric requirements.

Comment: Two commenters recommended revising the simulation training to "ongoing" from every six months in §157.126(h)(12)(G).

Response: DSHS disagrees and declines to revise the language. The department received multiple comments supporting the pediatric readiness requirements.

Comment: One commenter supports the pediatric readiness language in §157.126(h)(13).

Response: DSHS appreciates the comment No revisions are made in response to this comment.

Comment: Multiple commenters recommended increasing the APP response time from 15 minutes to 30 minutes in §157.126(h)(14).

Response: DSHS agrees and modifies the response time to 30 minutes.

Comment: Multiple commenters recommended revising the TMD defining "the role and expectations of the hospitalist or intensivist" to the TMD "collaborating or overseeing" the physicians in §157.126(h)(16).

Response: DSHS disagrees and declines to revise the language. The TMD has the overall authority for trauma patients and the care provided in the hospital.

Comment: Multiple commenters recommended removing requirement §157.126(h)(17).

Response: DSHS disagrees and declines to revise the language. The Trauma Program Manager (TPM) or designee allows the facility flexibility in meeting the mandatory composition while maintaining trauma program representation on the committee.

Comment: Several commenters recommended revising the language in §157.126(h)(19) and applying the requirement to Medical Staff Services in the hospital.

Response: DSHS acknowledges the comments and declines to revise the language. The requirement aligns with the ACS standards.

Comment: Two commenters recommended removing the TMD requirement to "complete a trauma performance improvement course approved by the department" in §157.126(h)(20).

Response: DSHS disagrees and declines to remove the language. It is essential for the TMD to complete the course to ensure the trauma performance improvement plan and process meets the requirements and improves patient care.

Comment: Multiple commenters recommended adding the same certifications required for nursing staff participating in trauma care to the TPM role in §157.126(h)(21).

Response: DSHS agrees and adds "have current TNCC or ATCN, Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS), Advanced Cardiac Life Support (ACLS) certifications."

Comment: One commenter recommended in §157.126(h)(21) that if the Trauma Registrar has completed the AAAM course it meets the requirement for the TPM.

Response: DSHS disagrees and declines to revise the requirement. Completion of the AAAM course by the TPM provides the knowledge needed to lead the trauma program and oversee the Trauma Registrar and the trauma registry.

Comment: One commenter recommended adding a full-time equivalent (FTE) for the TPM in §157.126(h)(21).

Response: DSHS disagrees and declines to add the language. It is the facility's responsibility to provide the resources and personnel to meet the requirements for a deficiency-free, successful trauma designation program.

Comment: One commenter recommended revising the language in §157.126(h)(25) to allow the TMD to participate in the trauma multidisciplinary peer review committee or hospital performance improvement (PI)/peer committee, instead of being the chairperson.

Response: DSHS disagrees and declines to revise the language. The requirement applies to Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually. The TMD is required to have the expertise and oversight of trauma care in the facility, which makes them the most appropriate individual to chair the review committee.

Comment: Two commenters recommended adding an FTE for the Level IV Trauma Registrar in §157.126(h)(28)(A).

Response: DSHS disagrees and declines to revise the language. It is the facility's responsibility to provide the resources and personnel to meet the requirements for a deficiency-free, successful trauma designation program.

Comment: Multiple commenters recommended revising language to state "clinical leaders or providers" to generalize the required participants and to increase the training and mass casualty event from once every year to once every three years in §157.126(h)(30).

Response: DSHS disagrees and declines to revise the language. Training and practicing for the mass casualty within the hospital ensures better execution when the event occurs.

Comment: Two commenters recommended adding the TNCC or ATCN, ENPC or PALS, and ACLS certifications and a trauma program manager course to the requirement for the Level IV facilities managing 100 or less trauma patients in §157.126(h)(32)(C).

Response: DSHS agrees and adds the trauma program manager course and TNCC or ATCN, ENPC or PALS, and ACLS certifications to the language.

Comment: One commenter recommended clarification on §157.126(h)(32)(C) limiting the Chief Nursing Officer (CNO) to perform the TPM duties if a separate TPM is not identified, as it does not benefit the trauma program when other registered nurses may be available.

Response: DSHS acknowledges the comment and removes the language related to integrating the trauma functions into

the CNO functions. The trauma program is required to have a trauma program manager as defined in the language. It is the facility's decision if the TPM job functions are integrated into the Chief Nursing Officer (CNO) job functions.

Comment: Multiple commenters recommended modifying the language to require only one unit of blood or changing §157.126(h)(32)(L) to a desired requirement.

Response: DSHS disagrees and declines to revise the language because blood availability is important for trauma and other medical and obstetrical patient populations. The department will consider blood center allotments for trauma facilities limited to one unit of packed red blood cells when determining designation deficiencies.

Comment: Two commenters recommended clarifying "participation" in the RAC in §157.126(h)(32)(M).

Response: DSHS disagrees and declines to revise the language. The rule language is sufficient as participation is defined by the RAC and should be voted upon by the general membership.

Comment: Two commenters recommended maintaining the current survey team composition for Level I and II trauma facilities in §157.126(o)(1).

Response: DSHS agrees and revises the language to include two surgeons, an emergency medicine physician, and a registered nurse with trauma expertise.

Comment: Multiple commenters recommended maintaining the registered nurse surveyor for Level I and II trauma facilities in §157.126(o)(1).

Response: DSHS agrees and revises the language to include two surgeons, an emergency medicine physician, and a registered nurse with trauma expertise.

Comment: Multiple commenters support including the registered nurse surveyor or a trauma registered nurse leader in the survey team composition for all trauma facilities in §157.126(o)(2).

Response: DSHS agrees and adds a surgeon and a registered nurse with trauma expertise.

Comment: Multiple commenters support including the registered nurse surveyor or a trauma registered nurse leader in the survey team composition for all trauma facilities in §157.126(o)(3)(A) - (B).

Response: DSHS acknowledges the comments and revises the language.

Comment: Two commenters recommended including the registered nurse surveyor, removing only physician surveyors from the Level IV facilities, and including a surgeon surveyor with the determinations currently utilized by DSHS and TETAF in §157.126(o)(3)(A).

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: Several commenters recommended revising §157.126(o)(3)(A) to require only one surveyor, a surgeon or registered nurse, for the Level IV facilities managing 101 or more trauma patients annually.

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: One commenter recommended changing §157.126(o)(3)(A) to maintain the current survey team composition for Level IV facilities.

Response: DSHS acknowledges the comments and revises the surveyor requirements for each facility level, as appropriate for the services provided.

Comment: One commenter supports the inclusion of emergency medicine physicians or family practice physicians in the survey team composition for the Level IV facilities managing 100 or less trauma patients in §157.126(o)(3)(B).

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: Multiple commenters recommended maintaining the registered nurse surveyor and only a department-approved survey organization for Level IV designation surveys in §157.126(o)(3)(B).

Response: DSHS agrees to maintain a registered nurse surveyor and revises the language including a registered nurse with trauma expertise. DSHS disagrees with only a department-approved survey organization for the Level IV facilities with a low volume of trauma patients meeting NTDB registry inclusion criteria annually. The Level IV facilities may be evaluated for meeting the requirements by a department survey or a department-approved survey organization, at the discretion of the facility.

Comment: One commenter recommended removing a contiguous regional advisory council (RAC) as a conflict of interest for surveyors in §157.126(p)(1).

Response: DSHS disagrees and declines to revise the language. Trauma facilities may transfer patients to facilities in a contiguous RAC. A higher-level facility receiving patients from these facilities is a conflict of interest for conducting surveys.

Comment: One commenter supports the language in requirement §157.126(p)(2)(A) regarding surveyor conflicts when a direct or indirect financial, personal, or other interest would limit or affect their ability to serve.

Response: DSHS appreciates the comment. No revisions are made in response to this comment.

Comment: One commenter recommended removing the language in §157.126(p)(2)(B) regarding a surveyor who has had a prior working relationship in various capacities with a facility or the personnel in the past four years because it is too prescriptive.

Response: DSHS disagrees and declines to remove the language to decrease any surveyor conflicts or perceived conflicts of interest.

Comment: Two commenters recommended changing "protocols" to "guidelines" in §157.130(a)(4)(C)(ii) and deleting "in all TSAs where EMS is provided and verified by each RAC."

Response: DSHS disagrees and declines to modify the language. No revisions are required as "protocols" is not present in the language. All Trauma Services Areas (TSAs) are included in the language for RACs to receive credit and funding for EMS runs occurring in their area.

Comment: Two commenters recommended clarification on the requirement in §157.130(a)(4)(C)(iii) because EMS reporting to the RAC is overly burdensome.

Response: DSHS disagrees and declines to modify the language. The language requires EMS providers eligible for funds in a specific RAC to participate in the RACs where they provide services and may receive funds.

Comment: Two commenters recommended clarification on which requirement the language refers to in §157.130(a)(4)(D).

Response: DSHS agrees and relocates language from (a)(4)(D) to (a)(4)(G) to align with EMS provider county contract requirement.

Comment: Two commenters recommended deleting "and expectations" from §157.130(a)(5)(B)(ii).

Response: DSHS disagrees because the language "and expectations" is not present.

Comment: Two commenters recommended modifying the language in §157.130(a)(6)(C) from a facility "that fails to maintain its designation," to a facility "that is denied designation."

Response: DSHS disagrees and declines to revise the language to "denied." Trauma designated facilities are required to meet trauma designation requirements when submitting an application to receive trauma funding for trauma patient care.

Comment: Two commenters recommended revising the language in §157.130(a)(6)(E) to include "good standing with their RAC" before receiving any future disbursements.

Response: DSHS disagrees and declines to revise the language. The funding is dispersed by the state of Texas. Therefore, state requirements must be met, and any funds owed by the facility to the state would be reconciled.

DSHS revises §157.2(9) to correct a reference that was missing a parenthesis.

DSHS moves "annually" in the Level IV facility descriptions to follow "inclusion criteria" in §157.2(20), §157.126(g)(4)(A) and (B), (h)(19), (21), (25), (30) - (32), (n), (n)(3) - (4), and (o)(3)(A) and (B) to clarify the requirement is not inclusive of all trauma patients annually, but only those "meeting NTDB registry inclusion criteria annually."

DSHS revises §157.2(32) to make allowances for facilities transferring patients out from the emergency department.

DSHS deletes "and system plan" from the §157.2(142) definition because it is redundant.

DSHS replaces "evaluated" with "managed" in §157.125(t) for consistent language with §157.2(20), §157.126(g)(4)(A) and (B), (h)(8), (h)(19) - (21), (h)(25), (h)(30) - (32), (n), (n)(3) - (4), (o)(3), and (o)(3)(A) and (B).

DSHS removes "in order" from §157.125(t) because it is not necessary.

DSHS deletes "surgeon" in §157.125(x)(18) after neurosurgeon because it is a duplication.

DSHS revises §157.125(y)(19) to "in collaboration with the RAC or their health care system" adding another option for facilities providing education to staff physicians, nurses, and allied health personnel, including APPs.

DSHS deletes "evaluating and" from §157.126(h)(12)(G) and (h)(13) to be consistent with revisions made to the rules. DSHS adds "emergency requests from" to §157.126(h)(15)(A) to further define the use of telemedicine for inpatient units.

DSHS adds "wristband number or patient tracking identifier" to §157.126(h)(18) to ensure documentation of §157.126(h)(4) in medical records.

DSHS revises §157.126(h)(20) to clarify the trauma medical director (TMD) requirements for the Level I, II, and III facilities remain aligned with the current ACS standards. Language was added to the Level IV facilities managing 101 or more trauma patients… "must have a TMD with a defined job description that is a surgeon, emergency medicine physician, or family practice physician that is board-certified in their specialty, current in ATLS, and meet the other ACS standards specific to the TMD for the level of designation requested."

DSHS adds "for the TPM" to §157.126(h)(21) to clarify the education is recommended for the TPM position.

DSHS moves "annually" after "inclusion criteria" in §157.126(o)(3) to be consistent with Level IV rule language in §157.2(20), §157.126(g)(4)(A) - (B), (h)(19) - (21), (h)(25), (h)(30-32), (n), (n)(3) - (4), and (o)(3)(A) - (B).

DSHS revises §157.126(o) to clearly separate and list the survey team members for each designation level. Language was revised to ensure appropriate grammar and consistent language in all survey team descriptions.

DSHS adds "organization" to §157.126(o)(3)(B) for consistent language in the requirement and §157.126(o)(3)(A).

DSHS revises the language in §157.126(n)(4) adding "or" for the option of a department-approved survey organization for consistent language with §157.2(20) Basic Level IV trauma facility.

DSHS removes "in writing" from §157.126(n)(4) because it is implied, and the language is sufficient.

DSHS adds "trauma" to the regional system in §157.126(t)(2)(A) for consistent language with §157.126(t)(2).

SUBCHAPTER A. EMERGENCY MEDICAL SERVICES - PART A

25 TAC §157.2

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes 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.

§157.2. Definitions.

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

(1) Abandonment--Leaving a patient without appropriate medical care once patient contact has been established, unless emergency medical services personnel are following the medical director's protocols, a physician directive, or the patient signs a release; or turning the care of a patient over to an individual of lesser education when advanced treatment modalities have been initiated.

(2) Accreditation--Formal recognition by a national association of a provider's service or an education program based on standards established by that association.

(3) Act--Emergency Health Care Act, Texas Health and Safety Code Chapter 773.

(4) Active pursuit of department designation as a trauma facility--An undesignated facility recognized by the department after applying for designation as a trauma facility and has met the requirement to be eligible for uncompensated trauma care funds.

(5) Acute Stroke-Ready Level IV stroke facility--A hospital reviewed by a department-approved survey organization and meeting the national stroke standards of care for an acute stroke-ready facility as described in §157.133 of this chapter (relating to Requirements for Stroke Facility Designation).

(6) Administrator of record (AOR)--The administrator for an emergency medical services (EMS) provider who meets the requirements of Texas Health and Safety Code §773.05712.

(7) Advanced emergency medical technician (AEMT)--An individual certified by the department and minimally proficient in performing the basic life support skills required to provide emergency prehospital or interfacility care and initiating and maintaining under medical supervision, certain advanced life support procedures, including intravenous therapy and endotracheal or esophageal intubation.

(8) Advanced Level II stroke facility--A hospital that completes a designation survey with a department-approved survey organization, meets the national stroke standards for Non-Comprehensive Thrombectomy Stroke Center, and meets the requirements of an Advanced Level II stroke facility as defined by §157.133 of this chapter.

(9) Advanced Level III trauma facility--A hospital surveyed by a department-approved survey organization that meets the state requirements and American College of Surgeons (ACS) standards for a Level III trauma facility as described in §157.125 of this chapter (relating to Requirements for Trauma Facility Designation Effective Through August 31, 2025) and §157.126 of this chapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025).

(10) Advanced life support (ALS)--Emergency prehospital or interfacility care that uses invasive medical acts and includes ALS assessment. The provision of advanced life support must be under the medical supervision and control of a licensed physician.

(11) Advanced life support assessment--Assessment performed by an AEMT or paramedic that qualifies as advanced life support based upon initial dispatch information, when it could reasonably be believed the patient was suffering from an acute condition that may require advanced skills.

(12) Advanced life support vehicle--A vehicle designed for transporting the sick and injured and meeting the requirements of §157.11 of this chapter (relating to Requirements for an EMS Provider License) as an ALS vehicle and having sufficient equipment and supplies for providing an advanced level of care based on national standards and the EMS provider's medical director-approved treatment protocols.

(13) Advanced practice provider (APP)--A nurse practitioner or physician assistant reviewed and credentialed by the facility and may have additional credentialing to participate in the designation program.

(14) Air ambulance provider--A person who operates, maintains, or leases a fixed-wing or rotor-wing air ambulance aircraft, equipped and staffed to provide a medical care environment on-board appropriate to the patient's needs. The term air ambulance provider is not synonymous with and does not refer to the Federal Aviation Administration (FAA) air carrier certificate holder unless the air ambulance provider maintains and controls the medical aspects consistent with EMS provider licensure.

(15) Ambulance--A vehicle for transportation of the sick or injured patient to, from, or between places of treatment for an illness or injury and that provides out-of-hospital medical care to the patient.

(16) American College of Surgeons (ACS)--The organization that sets the national standards for trauma centers, trauma verification, the National Trauma Data Standards (NTDS), National Trauma Data Bank (NTDB), Trauma Quality Improvement Program (TQIP), and regional system standards.

(17) Approved survey organization--An organization that has received department authorization to conduct designation surveys, meeting the department's designation survey guidelines and expectations.

(18) Authorized ambulance vehicle--A vehicle authorized to be operated by the licensed provider and meeting all criteria for approval as described in §157.11(e) of this chapter.

(19) Bad debt--The unreimbursed cost for patient care to a hospital providing trauma care.

(20) Basic Level IV trauma facility--A hospital managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually surveyed by a department-approved survey organization and meeting the state requirements and ACS standards, or a hospital managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually surveyed by the department or a department-approved survey organization, and meeting the state designation requirements for a Level IV trauma facility as described in §157.125 and §157.126 of this chapter.

(21) Basic life support (BLS)--Emergency prehospital or interfacility care that uses noninvasive medical acts. The provision of basic life support will have sufficient equipment and supplies for providing basic-level care based on national standards and the EMS provider's medical director-approved treatment protocols.

(22) Basic life support (BLS) vehicle--A vehicle designed for transporting the sick or injured and having sufficient equipment and supplies for providing basic life support based on national standards and the EMS provider's medical director-approved treatment protocols.

(23) Bypass--Direction given to prehospital emergency medical services personnel by direct on-line medical control, or off-line medical director protocols to bypass the nearest facility for the most appropriate facility.

(24) Calculation of the costs of uncompensated trauma care--A calculation of a hospital's total costs of uncompensated trauma care for patients meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria determined by summing its charges related to uncompensated trauma care as defined in §157.130 of this chapter (relating to Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Services Account), then

applying the cost-to-charge ratio derived in accordance with generally accepted accounting principles.

(25) Candidate--An individual requesting emergency medical services personnel certification, licensure, recertification, or re-licensure from the department.

(26) Certificant--Emergency medical services personnel with current certification from the department.

(27) Charity care--The unreimbursed cost to a hospital providing health care services for an inpatient, emergency department, transferred, or expired person classified by the hospital as "financially indigent."

(28) Commissioner--The commissioner of the Texas Department of State Health Services.

(29) Comprehensive Level I stroke facility--A hospital surveyed by a department-approved survey organization meeting the national standards of care for a Comprehensive Stroke Center, participates in its local Regional Advisory Council (RAC), participates in the regional stroke plan, and submits data to the department, as requested as defined by §157.133 of this chapter.

(30) Comprehensive Level I trauma facility--A hospital surveyed by a department-approved survey organization meeting the state designation requirements and ACS standards for a Level I trauma facility as described in §157.125 and §157.126 of this chapter.

(31) Concurrent performance improvement--Performance improvement reviews occurring from prehospital, trauma activation, or admission through to discharge. The primary level of review must be completed within 14 days of discharge, 80 percent of the time.

(32) Concurrent trauma registry abstraction--Trauma registry data abstraction and registry data entry occurring after the management of the trauma patient and completed within 60 days after the patient's discharge, 80 percent of the time.

(33) Consumer Protection Division (CPD)--A division within the Texas Department of State Health Services responsible for the oversight of EMS provider licensure, certification, education, and complaint investigation. The division is responsible for the hospital designation process for trauma, stroke, maternal, and neonatal facilities; the RAC system development and advances; and funding, grant management, and distribution of funding for the division.

(34) Contingent designation--A designation awarded to a facility with one to three unmet designation requirements. The department develops a corrective action plan (CAP) for the facility and the facility must complete this plan and meet requirements to remain designated. Contingent designations may require a focused survey to validate requirements are met. The facility must demonstrate requirements are met to maintain designation.

(35) Contingent probationary designation--A designation awarded to a facility with four or more unmet designation requirements. The department develops a CAP for the facility and the facility must complete this plan and meet requirements to remain designated. The facility may be required to submit documentation reflecting the CAP to the department at defined intervals. Contingent probationary designation may require a full survey within 12 to 18 months after the original survey date. The facility must demonstrate requirements are met to maintain designation.

(36) Corrective action plan (CAP)--A plan for the facility developed by the department describing the actions the facility is required to correct.

(37) Cost-to-charges ratio--A ratio covering all applicable hospital costs and charges relating to inpatient care determined by the Texas Health and Human Services Commission from the hospital's Medicaid cost report.

(38) County of licensure--The county in which the physical address of a licensed EMS provider is located, as indicated by the provider on the application for licensure that is filed with the department.

(39) Course medical director--A Texas-licensed physician, approved by the department, with experience in and current knowledge of emergency care who must provide direction over all instruction and clinical practice required in EMS training courses.

(40) Credit hour--Continuing education credit unit awarded for successful completion of a unit of learning activity as defined in §157.32 of this chapter (relating to Emergency Medical Services Education Program and Course Approval).

(41) Critically injured person--An individual suffering with multi-system injuries or major single-system injury; the extent of the injury may be difficult to ascertain but has the potential of producing mortality or major disability.

(42) Definitive care--The phase of care in which therapeutic interventions, treatments, or procedures are performed to stop or control an injury, illness, or disease and promote recovery.

(43) Department--The Texas Department of State Health Services.

(44) Designated facility administrator--Administrator responsible for the oversight, funding, contracts, and leadership of designated programs.

(45) Designated infection control officer--A designated officer who serves as a liaison between the employer and the employees who have been or believe to have been exposed to a potentially life-threatening infectious disease through a person who was treated or transported by the EMS provider.

(46) Designation--A formal recognition by the department of a hospital's capabilities, commitment, care practices, and participation in the RAC to serve as a designated facility.

(47) Designation appeal--The process for a hospital that has been downgraded or denied a specific level of designation to appeal the designation decision.

(48) Designation survey--An on-site or virtual review of a facility applicant to determine if it meets the criteria for a particular level of designation.

(49) Dispatch--The sending of individuals and equipment by EMS for assessment, prompt efficient treatment, and transportation, if required, of a sick or injured patient.

(50) Distance learning--A method of learning remotely without being in regular face-to-face contact with an instructor in the classroom.

(51) Diversion--A procedure put into effect by a health care facility notifying EMS when that facility is unable to provide the level of care demanded by a patient's injuries or condition due to lack of capacity or capabilities, or when the facility has temporarily exhausted its resources and requesting patients be transported to another facility.

(52) Emergency call--A call or other similar communication from a member of the public, as part of a 9-1-1 system or other emergency access communication system, made to obtain emergency medical services.

(53) Emergency care attendant (ECA)--An individual who is certified by the department as minimally proficient in performing emergency prehospital care by providing initial aid that promotes comfort and avoids aggravation of an injury or illness.

(54) Emergency medical services (EMS)--Services used to respond to an individual's perceived need for medical care and to prevent death or aggravation of physiological or psychological illness or injury.

(55) EMS medical director--The licensed physician who provides medical supervision to the EMS personnel of a licensed EMS provider or a recognized first responder organization (FRO) under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board; may also be called "off-line medical control."

(56) Emergency medical services operator--An individual who, as an employee of a public or private agency, receives emergency calls and may provide medical information or medical instructions to the public during those emergency calls.

(57) Emergency medical services personnel--

(A) emergency care attendant (ECA);

(B) emergency medical technician (EMT);

(C) advanced emergency medical technician (AEMT);

(D) emergency medical technician-paramedic (EMT-P); or

(E) licensed paramedic (LP).

(58) Emergency medical services provider--An organization that uses, operates, or maintains EMS vehicles and EMS personnel to provide emergency medical services.

(59) Emergency medical services times--

(A) Time of call--The date and time a phone rings at a public safety answering point (PSAP) or other designated entity, requesting EMS services.

(B) Dispatch time--The date and time a responding EMS provider is notified by dispatch.

(C) En route--The date and time the EMS vehicle starts moving to respond.

(D) On scene--The date and time a responding EMS vehicle stops moving when it arrives at the location of the response.

(E) At patient side--The date and time the EMS personnel of the responding EMS vehicle arrives at the patient's side.

(F) Transport--The date and time the responding EMS vehicle leaves the location of the response and starts moving toward the destination.

(G) Arrival time--The date and time the responding EMS vehicle arrives with the patient at the destination or transfer point.

(H) Transfer of care--The date and time patient care is transferred to the destination health care staff or transfer point of health care.

(I) Back in service--The date and time the EMS vehicle is back in service and available for another response.

(60) Emergency medical services vehicle--

(A) basic life support (BLS) vehicle;

(B) advanced life support (ALS) vehicle;

(C) mobile intensive care unit (MICU) vehicle;

(D) MICU rotor-wing and MICU fixed-wing air medical vehicles; or

(E) specialized emergency medical service vehicle.

(61) Emergency medical services volunteer--EMS personnel who provide emergency prehospital or interfacility care in affiliation with a licensed EMS provider or a registered FRO without remuneration, except for reimbursement for expenses.

(62) Emergency medical services volunteer provider--An EMS provider with at least 75 percent of personnel as volunteers and is a nonprofit organization. See §157.11 of this chapter regarding fee exemption.

(63) Emergency medical technician (EMT)--An individual certified by the department as minimally proficient in performing emergency prehospital care necessary for basic life support and includes the control of hemorrhaging and cardiopulmonary resuscitation.

(64) Emergency medical technician-paramedic (EMT-P)--An individual certified by the department as minimally proficient in performing emergency prehospital or interfacility care in health care facility's emergency or urgent care clinical setting, including a hospital emergency room and a freestanding emergency medical care facility, by providing advanced life support that includes initiation and maintenance under medical supervision of certain procedures, including intravenous therapy, endotracheal or esophageal intubation or both, electrical cardiac defibrillation or cardioversion, and drug therapy.

(65) Emergency prehospital care--Care provided to the sick and injured within a health care facility's emergency or urgent care clinical setting, including a hospital emergency room and freestanding emergency medical care facility, before or during transportation to a medical facility, including any necessary stabilization of the sick or injured in connection with transportation.

(66) Event--A variation from the established care management guidelines or system operations such as delays in response, delays in care, hospital event such as complications, or death. An event or variation in care creates a need for review of the care or system processes to identify opportunities for improvement.

(67) Event resolution--An event, as described in paragraph (66) of this section, that is identified and reviewed to determine the impact to the patient and if opportunities for improvement in care or the system exist, with a specific action plan tracked with data analysis to demonstrate the action plan created the desired change to achieve the desired goal, and improved outcomes are sustained.

(68) Extraordinary emergency--A serious, unexpected event or situation requiring immediate action to reduce or minimize disruption to established health care services within the EMS and trauma care system.

(69) Field triage--The process of determining which facility is most appropriate for patients based on injury severity, time-sensitive disease factors, and facility availability. Refer to paragraph (104) of this section.

(70) Financially indigent--An uninsured or underinsured patient unable to pay for the trauma services rendered based on the hospital's eligibility system.

(71) First responder organization (FRO)--A group or association of certified EMS personnel that work in cooperation with licensed EMS providers.

(72) Fixed location--The address as it appears on the initial or renewal EMS provider license application in which the patient care records and administrative departments are located.

(73) Governmental entity--A county, a city or town, a school district, or a special district or authority created in accordance with the Texas Constitution, including a rural fire prevention district, an emergency services district, a water district, a municipal utility district, and a hospital district.

(74) Governor's EMS and Trauma Advisory Council (GETAC)--An advisory council appointed by the Governor of Texas that provides professional recommendations to the EMS/Trauma System Section regarding EMS and trauma system development and serves as a forum for stakeholder input.

(75) Inactive EMS provider status--The period of time when a licensed EMS provider is not able to respond to an EMS dispatch.

(76) Industrial ambulance--Any vehicle owned and operated by an industrial facility as defined in the Texas Transportation Code §541.201 and used for initial transport or transfer of company employees who become urgently ill or injured on company premises to an appropriate health care facility.

(77) Injury severity score (ISS)--An anatomical scoring system providing an overall score for trauma patients. The ISS standardizes the severity of trauma injuries based on the three worst abbreviated injury scales (AIS) from the body regions. These regions are the head and neck, face, chest, abdomen, extremity, and external as defined by the Association for the Advancement of Automotive Medicine (AAAM). The highest abbreviated injury score in the three most severely injured body regions have the scores squared, then added together to define the patient's ISS.

(78) Interfacility care--Care provided while transporting a patient between health care facilities.

(79) Legal entity name--The name of the lawful or legally standing association, corporation, partnership, proprietorship, trust, or individual. Has legal capacity to:

(A) enter into agreements or contracts;

(B) assume obligations;

(C) incur and pay debts;

(D) sue and be sued in its own right; and

(E) to be accountable for illegal activities.

(80) Level of harm--A classification system defining the impact of an event to the patient and assists in defining the urgency of review. There are five levels of harm used to define the impact to the patient as defined by the American Society for Health Care Risk Management:

(A) No harm--The patient was not symptomatic or no symptoms were detected, and no treatment or intervention was required.

(B) Mild harm--The patient was symptomatic, symptoms were mild, loss of function or harm was either minimal or intermediate but short-term, and no interventions or only minimal interventions were needed.

(C) Moderate harm--The patient was symptomatic, required intervention such as additional operative procedure, therapeutic treatment, or an increased length of stay, required a higher level of care, or may experience long-term loss of function.

(D) Severe harm--The patient was symptomatic, required life-saving or other major medical or surgical intervention, or may experience shortened life expectancy, and may experience major permanent or long-term loss of function.

(E) Death harm--The event was a contributing factor in the patient's death.

(81) Levels of review--Describes the levels of performance improvement review for an event in the designation program's quality improvement or performance improvement patient safety (PIPS) plan. There are four levels of review:

(A) Primary level of review--Initial investigation of identified events by the facility's designation program performance improvement personnel to capture the event details and to validate and document the timeline, contributing factors, and level of harm. The program manager usually addresses system issues with no level of harm, including identifying the opportunities for improvement and action plan appropriate for the event, and keeping the program medical director updated. This must be written in the facility's performance improvement plan.

(B) Secondary level of review--The level of review by the facility's designation program medical director in which the program personnel prepare the documentation and facts for the review. The program medical director reviews the documentation and either agrees or corrects the level of harm, defines the opportunities for improvement with action plans, or refers to the next level of review.

(C) Tertiary level of review--The third level of review by the facility's designation program to evaluate care practices and compliance to defined management guidelines, identify opportunities for improvement, and define a plan of correction (POC). Minutes capturing the event, discussion, and identified opportunities for improvement with action plans must be documented.

(D) Quaternary level of review--The highest level of review, which may be conducted by an entity external to the facility program as an element of the performance improvement plan. The event, review, and discussion of the event, and identified opportunities for improvement with action plans must be documented.

(82) Licensee--A person who holds a current paramedic license from the department, or an organization that uses, maintains, or operates EMS vehicles and provides EMS personnel to provide emergency medical services, and who holds an EMS provider license from the department.

(83) Major Level II trauma facility--A hospital surveyed by a department-approved survey organization meeting the state designation requirements and ACS standards for a Level II trauma facility as described in §157.125 and §157.126 of this chapter.

(84) Major trauma patient--An individual with injuries, or potential injuries, who benefits from treatment at a trauma facility. The patient may or may not present with alterations in vital signs or level of consciousness, or with obvious, significant injuries, but has been involved in an event that produces a high index of suspicion for significant injury and potential disability. Co-morbid factors such as age or the presence of significant preexisting medical conditions are also considered. The patient initiates a system response to include field triage to the most appropriate designated trauma facility.

(85) Medical control--The supervision of prehospital EMS providers and FROs by a licensed physician. This encompasses on-line (direct voice contact) and off-line (written protocol and procedural review).

(86) Medical oversight--The assistance and management given to health care providers and entities involved in regional EMS/trauma systems planning by a physician or group of physicians designated to provide technical assistance to the EMS provider or FRO medical director.

(87) Medical supervision--Direction given to EMS personnel by a licensed physician under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board.

(88) Mobile intensive care unit--A vehicle designed for transporting the sick or injured, meeting the requirements of the advanced life support vehicle, and having sufficient equipment and supplies to provide cardiac monitoring, defibrillation, cardioversion, drug therapy, and two-way communication with at least one paramedic on the vehicle when providing EMS.

(89) National EMS Compact--The agreement among states to allow the day-to-day movement of EMS personnel across state boundaries.

(90) National EMS Information System (NEMSIS)--A universal standard for how patient care information resulting from an EMS response is collected.

(91) National Trauma Data Bank (NTDB)--The national repository for trauma registry data, defined by the ACS with inclusion criteria and data elements required for submission.

(92) National Trauma Data Standards (NTDS)--The American College of Surgeons' standard data elements with definitions required for submission to the NTDB, as defined in paragraph (91) of this section.

(93) Non-contiguous emergency department--A hospital emergency department located in a separate building, not contiguous with the designated facility. May be referred to as a satellite emergency department.

(94) Off-line medical director--The licensed physician who provides approved protocols and medical supervision to the EMS personnel of a licensed EMS provider under the terms of the Medical Practice Act (Texas Occupations Code Chapters 151 - 165) and rules promulgated by the Texas Medical Board.

(95) On-line course--A directed learning process comprised of educational information (articles, videos, images, web links), communication (messaging, discussion forums) for virtual learning, and measures to evaluate the student's knowledge.

(96) Operational name--Name under which the business or operation is conducted and presented to the world.

(97) Operational policies--Policies and procedures that are the basis for the provision of EMS and that include such areas as vehicle maintenance; proper maintenance and storage of supplies, equipment, medications, and patient care devices; complaint investigations; multi-casualty incidents; and hazardous materials; but do not include personnel or financial policies.

(98) Operations Committee--Committee serving as the facility's trauma program administrative oversight for designation and responsible for the approval of trauma management guidelines, operational plan, and procedures within the program or system having the potential to impact care practices or designation.

(99) Operative or surgical intervention--Any surgical procedure provided to address trauma injuries for patients taken directly from the scene, emergency department, or other hospital location to an operating suite for patients meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria.

(100) Out of service vehicle--The period of time when a licensed EMS vehicle is unable to respond to an emergency or non-emergency response.

(101) Performance improvement and patient safety (PIPS) plan--The written plan and processes for evaluating patient care, system response, and adherence to established patient management guidelines; defining variations from care or system response; assigning the level of harm and level of review; identifying opportunities for improvement; and developing the CAP. The CAP outlines data analysis and measures to track the action plan to ensure the desired changes are met and maintained to resolve the event. The medical director, program manager, and administrator have the authority and oversight over PIPS.

(102) Plan of correction (POC)--A report submitted to the department by the facility detailing how the facility will correct one or multiple requirements defined as "not met" during a trauma designation survey review that is reported in the survey summary or documented in the self-attestation.

(103) Practical exam--An evaluation that assesses the person's ability to perceive instructions and perform motor responses, also referred to as a psychomotor exam.

(104) Prehospital triage--The process of identifying medical or injury acuity or the potential for severe injury based upon physiological criteria, injury patterns, and high-energy mechanisms and transporting patients to a facility appropriate for the patient's medical or injury needs. Prehospital triage for injured patients or time-sensitive disease events is guided by the approved prehospital triage guidelines adopted by the RAC and approved by the department. May also be referred to as "field triage" or "prehospital field triage."

(105) Primary EMS provider response area--The geographic area in which an EMS agency routinely provides emergency EMS as agreed upon by a local or county governmental entity or by contract.

(106) Primary Level III stroke facility--A hospital designated by the department and meets the department-approved national stroke standards of care for a primary stroke center, participates in its RAC, participates in the regional stroke plan, and submits data as requested by the department.

(107) Protocols--A detailed, written set of instructions by the EMS provider's medical director, which may include delegated standing medical orders, to guide patient care or the performance of medical procedures as approved.

(108) Public safety answering point (PSAP)--The call center responsible for answering calls to an emergency telephone number for ambulance services; sometimes called "public safety access point" or "dispatch center."

(109) Quality management--Quality assessment, quality improvement, and performance improvement activities. See definition of PIPS in paragraph (101) of this section.

(110) Receiving facility--A health care facility to which an EMS vehicle may transport a patient requiring prompt continuous medical care, or a facility receiving a patient being transferred for definitive care.

(111) Recertification--The procedure for renewal of EMS certification.

(112) Reciprocity--The recognition of certification or privileges granted to an individual from another state or recognized EMS system.

(113) Regional Advisory Council (RAC)--A nonprofit organization recognized by the department and responsible for system coordination for the development, implementation, and maintenance of the regional trauma and emergency health care system within its geographic jurisdiction of the Trauma Service Area. A RAC must maintain 501(c)(3) status.

(114) Regional Advisory Council Performance Improvement Plan--A written plan of the RAC's processes to review identified or referred events, identify opportunities for improvement, define action plans and data required to correct the event, and establish measures to evaluate the action plan through to event resolution.

(115) Regional medical control--Physician supervision for prehospital EMS providers in a given trauma service area (TSA) or other geographic area intended to provide standardized oversight, treatment, and transport guidelines, which should, at minimum, follow the RAC's regional trauma and emergency health care system plan components related to these issues and 22 Texas Administrative Code §197.3 (relating to Off-line Medical Director).

(116) Relicensure--The procedure for renewal of a paramedic license as described in §157.40 of this chapter (relating to Paramedic Licensure); the procedure for renewal of an EMS provider license as described in §157.11 of this chapter.

(117) Response pending status--The status of an EMS vehicle that just delivered a patient to a final receiving facility and for which the dispatch center has another EMS response waiting.

(118) Response ready--When an EMS vehicle is equipped and staffed in accordance with §157.11 of this chapter and is immediately available to respond to any emergency call 24-hours per day, seven days per week (24/7).

(119) Rural county--A county with a population of less than 50,000 based on the latest estimated federal census population figures.

(120) Scope of practice--The procedures, actions, and processes EMS personnel are authorized to perform as approved by the EMS provider's medical director.

(121) Scope of services--The types of services and the resources to provide those services that a facility has available.

(122) Severe trauma patient--A person with injuries or potential injuries defined as high-risk for mortality or disability and meeting trauma activation guidelines and meeting NTDB registry inclusion criteria benefitting from definitive treatment at a designated trauma facility. These patients may be identified by an alteration in vital signs or level of consciousness or by the presence of significant injuries and must initiate a level of trauma response defined by the facility, including prehospital triage to a designated trauma facility.

(123) Simulation training--Training, typically scenario-based or skill-based, utilizing simulated patients or system events to improve or assess knowledge, competencies, or skills.

(124) Sole provider--The only licensed EMS provider in a geographically contiguous service area and in which the next closest provider is greater than 20 miles from the limits of the area.

(125) Specialized EMS vehicle--A vehicle designed for responding to and transporting sick or injured persons by any means of transportation other than by standard automotive ground ambulance or rotor or fixed-wing aircraft and that has sufficient staffing, equipment, and supplies to provide for the specialized needs of the patient transported. This category includes watercrafts, off-road vehicles, and specially designed, configured, or equipped vehicles used for transporting special care patients such as critical neonatal or burn patients.

(126) Specialty resource centers--Entities caring for specific types of patients such as pediatric, cardiac, and burn injuries that have received certification, categorization, verification, or other forms of recognition by an appropriate agency regarding the capability to definitively treat these types of patients.

(127) Staffing plan--A document indicating the overall working schedule patterns of EMS or hospital personnel.

(128) Standard of care--Care equivalent to what any reasonable, prudent person of like education or certification level would have given in a similar situation, based on documented, evidence-based practices or adopted standard EMS curricula as adopted by reference in §157.32 of this chapter; also refers to the documented standards of care reflecting evidence-based practice.

(129) State EMS Registry--State repository for the collection of EMS response data as defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(130) State Trauma Registry--Statewide database managed by the department; responsible for the collection, maintenance, and evaluation of medical and system information related to required reportable events as defined in Chapter 103 of this title.

(131) Stroke--A time-sensitive medical condition occurring when the blood supply to the brain is reduced or blocked, caused by a ruptured blood vessel or clot, preventing brain tissue oxygenation.

(132) Stroke activation--The process of mobilizing the stroke care team when a patient screens positive for stroke symptoms; may be referred to as a "stroke alert" or "code stroke."

(133) Stroke facility--A hospital that has successfully completed the designation process and is capable of resuscitating and stabilizing, transferring, or providing definitive treatment to stroke patients and actively participates in its local RAC and system plan.

(134) Stroke medical director (SMD)--A physician meeting the department's requirements for the stroke medical director and having the authority and oversight for the stroke program, including the performance improvement process, data management, and outcome reviews.

(135) Stroke program manager (SPM)--A registered nurse meeting the requirements for the stroke program manager and having the authority and oversight for the stroke program, including the performance improvement process, data management, and outcome reviews.

(136) Substation--An EMS provider station location, not the fixed station, and likely to provide rapid access to a location to which the EMS vehicle may be dispatched.

(137) Telemedicine medical service--A health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or technology as defined in Texas Occupations Code §111.001.

(138) Transport mode--As documented on the patient care record, the usage of emergency warning equipment when responding to an EMS dispatch and when transporting a patient to a receiving facility.

(139) Trauma--An injury or wound to a living body caused by the application of an external force or violence, including burn injuries, and meeting the trauma program's trauma activation guidelines.

(140) Trauma activation guidelines--Established criteria identifying the potential injury risk to the human body and defining the resources and response times required to evaluate, resuscitate, and stabilize the trauma patient. The guidelines must meet the national recommendations, but each trauma program defines the activation guidelines for the facility. The facility may choose to have one activation level, two activation levels, or three activation levels.

(A) The highest level of trauma activation is commonly based on physiological changes in the patient's level of consciousness, airway or potential respiratory compromise, hypotension or signs of shock, significant hemorrhage, or evidence of severe trauma.

(B) The second level of trauma activation is commonly based on the patient's physiological stability with anatomical injuries or mechanisms of injury having the potential for serious injuries.

(C) The third level of trauma activation is designed for low-energy or single-system injuries that may require specialty service evaluation and intervention.

(141) Trauma administrator--Administrator responsible for the facility oversight, funding, contracts, and collaborative leadership of the program, and serves as an interface with the chief executive team as defined by the facility's organizational structure.

(142) Trauma and emergency health care system plan--The inclusive system that refers to the care rendered after a traumatic injury or time-sensitive disease or illness where the optimal outcome is the critical determinant. The system components encompass special populations, epidemiology, risk assessments, surveillance, regional leadership, system integration, business or finance models, prehospital care, definitive care facilities, system coordination for patient flow, prevention and outreach, rehabilitation, emergency preparedness and response, system performance improvement, data management, and research. These components are integrated into the regional self-assessment.

(143) Trauma care--Care provided to an injured patient meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria and the continuum of care throughout the system, including discharge and follow-up care or transfer.

(144) Trauma Designation Review Committee--Committee responsible for reviewing trauma designation appeals, reviewing requirement exception and waiver requests, and outlining specific requirements not met in order to identify potential opportunities to improve future rule amendments.

(145) Trauma facility--A hospital that has successfully completed the designation process, is capable of resuscitating and stabilizing, transferring, or providing definitive treatment to patients meeting trauma activation criteria, and actively participates in its local RAC and the development of the regional trauma and emergency health care system plan.

(146) Trauma medical director (TMD)--A physician meeting the requirements and demonstrating the competencies and leadership for the oversight and authority of the trauma program as defined by the level of designation and having the authority and oversight for the trauma program, including the performance improvement and patient safety processes, trauma registry, data management, peer review processes, outcome reviews, and participation in the RAC (TMD or designee) and the development of the regional trauma and emergency health care system plan.

(147) Trauma patient--Any injured person who has been evaluated by a physician, a registered nurse, or EMS personnel, and found to require medical care in a trauma facility based on local or national medical standards.

(148) Trauma program manager (TPM)--A registered nurse who in partnership with the TMD and hospital administration is responsible for oversight and authority of the trauma program as defined by the level of designation, including the trauma performance improvement and patient safety processes, trauma registry, data management, injury prevention, outreach education, outcome reviews, and research as appropriate to the level of designation.

(149) Trauma Quality Improvement Program (TQIP)--The ACS risk-adjusted benchmarking program using submitted data to evaluate specific types of injuries and events to compare cohorts' outcomes with other trauma centers; assisting in defining opportunities for improvement in specific patient cohorts.

(150) Trauma registrar--An individual meeting the requirements and whose job responsibilities include trauma patient data abstraction, trauma registry data entry, injury coding, and injury severity scoring, in addition to registry report writing and data management skills specific to the trauma registry and trauma program.

(151) Trauma registry--A trauma facility database capturing required elements of trauma care for each patient.

(152) Trauma service area--Described in §157.122 of this subchapter (relating to Trauma Service Areas).

(153) Uncompensated trauma care--The sum of "charity care" and "bad debt." Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor (including Medicaid, Medicare, Children's Health Insurance Program (CHIP), or other health insurance programs) are not uncompensated trauma care.

(154) Urban county--A county with a population of 50,000 or more based on the latest estimated federal census population figures.

(155) Verification--Process used by the ACS to review a facility seeking trauma verification to validate the defined standards are met with documented compliance for successful trauma center verification. If a Level I or Level II facility is not verified by the ACS, the department cannot designate the facility.

(156) When in service--The period of time when an EMS vehicle is responding to an EMS dispatch, at the scene, or en route to a facility with a patient.

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

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Cynthia Hernandez
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SUBCHAPTER G. EMERGENCY MEDICAL SERVICES TRAUMA SYSTEMS

25 TAC §§157.123, 157.130, 157.131

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes 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 agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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25 TAC §§157.123, 157.125, 157.126, 157.128, 157.130

STATUTORY AUTHORITY

The amendments and new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Health and Safety Code Chapter 773 (Emergency Health Care Act), which authorizes the Executive Commissioner to adopt rules to implement emergency medical services and trauma care systems; Texas Health and Safety Code Chapter 773, Subchapter G, which provides for the authority to adopt rules related to emergency medical services and trauma services; and Texas Health and Safety Code §1001.075, which authorizes 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.

§157.123. Regional Advisory Councils.

(a) The department recognizes a Regional Advisory Council (RAC) as the coordinating entity for the development and advancement of the regional trauma and emergency health care system within the defined trauma service area (TSA) as described in §157.122 of this subchapter (relating to Trauma Service Areas).

(1) The department recognizes only one RAC for each TSA.

(2) Trauma, prehospital, perinatal, stroke, cardiac, disaster response, and emergency health care stakeholders in the TSA must be eligible for participation or membership in the RAC.

(b) A RAC must meet the following requirements to be recognized as a RAC:

(1) maintain incorporation as an entity exempt from federal income tax under §501(a) of the United States Internal Revenue Code of 1986, and its subsequent amendments, by being listed as an exempt organization under §501(c)(3) of the code, and to be eligible to receive, distribute, and utilize the emergency medical services (EMS), uncompensated care, and TSA allotments;

(2) submit required documentation to the department that includes, at a minimum, the following:

(A) a summary of regional trauma, prehospital, pediatric, geriatric, perinatal, stroke, cardiac, and emergency health care system activities;

(B) evidence of an annual summary of the EMS, trauma, and emergency health care system performance improvement plan; and

(C) a completed regional self-assessment by the end of each odd state fiscal year, and a current trauma and emergency health care system plan by the end of each even state fiscal year, with documented evidence the performance criteria are met;

(3) maintain external financial audits and financial statements as defined by the department; and

(4) maintain a current website to communicate with regional stakeholders.

(c) Each RAC must develop and maintain a regionally specific comprehensive trauma and emergency health care system plan. The plan must include all counties within the TSA and must be based on current industry standards and guidelines.

(1) The trauma and emergency health care system plan must address the following elements:

(A) epidemiology data resources available;

(B) integration of regional stakeholders, identified coalitions, and community partners pertinent to the priorities and needs identified through the regional self-assessment;

(C) regional guidelines for prehospital field triage and destination, treatment, transport, and transfer of patients with time-sensitive health care injuries or illnesses;

(D) prevention and outreach activities guided by data available;

(E) system coordination and patient flow;

(F) meaningful participation in regional disaster preparedness, planning, response, recovery, after-action review, data tracking needs, and support of the hospital preparedness stakeholders, including the identified health care coalition and the department;

(G) identification of system-wide health care education sponsored or coordinated through the RAC;

(H) execution of a systems performance improvement plan that aligns with the state system performance improvement plan, and includes regional outcome data;

(I) current pediatric readiness capabilities that identifies opportunities to improve pediatric readiness within the region;

(J) integration of public health and business community stakeholders; and

(K) guidelines to support regional research projects.

(2) All health care entities and identified coalition partners should participate in the regional planning process.

(d) A RAC must maintain the ability to collect and report data from each hospital within the TSA to facilitate emergency preparedness and response planning for a public health disaster, public health emergency, or outbreak of communicable disease, in a manner directed by the department and consistent with Texas Health and Safety Code §§81.027, 81.0443, 81.0444, and 81.0445.

(1) Unless otherwise directed by the department, at least once each calendar quarter, a RAC must collect and report to the department the following data from each hospital in their TSA:

(A) general beds available and occupied;

(B) intensive care unit (ICU) beds available and occupied;

(C) emergency department visits;

(D) hospital admissions;

(E) ventilators available and in use; and

(F) hospital deaths.

(2) The department may request more or less frequent collection or reporting or may request different information from individual RACs to adequately prepare for and respond to any public health disaster, public health emergency, outbreak of communicable disease, or federal reporting requirement relating to emergency preparedness and response.

(3) RACs must make the collected data publicly available by posting the data on the RAC's internet website.

(e) A RAC with at least one county within the region located on the international border of Texas and at least one county within the region adjacent to the Gulf of Mexico must provide guidelines and protocols related to trauma patient transfer and related services meeting the following requirements.

(1) The RAC must develop an advisory committee composed of equal representation from designated trauma facilities within the RAC.

(2) The advisory committee must develop regional protocols for managing the dispatch, triage, transport, and transfer of patients.

(A) The advisory committee must periodically review patient transfers ensuring the applicable protocols are met.

(B) Each hospital and EMS provider operating within this TSA must collect and report to the RAC data on patients transferred outside of the TSA following the developed and approved regional protocols.

(C) The advisory committee and activities must be integrated into the regional trauma and emergency health care system plan.

(f) A RAC must meet the defined performance criteria to ensure the mission of the regional system is maintained. A RAC must:

(1) notify the department and RAC membership within five days of the loss of capabilities to maintain the infrastructure to oversee and maintain the regional systems as required by the provisions within subsections (a) and (b) of this section or the department contract;

(2) provide the department with a plan of correction (POC) no more than 90 days from the onset of the deficiency for the RAC; and

(3) comply with the provisions of subsections (a) and (b) of this section, all current state and system standards as described in this chapter, and all guidelines and procedures as set forth in the regional trauma and emergency health care system plan.

(g) If a RAC chooses to relinquish services, it must provide at least a 30-day written advance notice to the department, all RAC membership, RAC coalition partners, and county judges within the impacted TSA.

(1) The RAC must submit a written plan to the department for approval before the 30-day notice to relinquish services.

(2) The RAC funding and assets must be dissolved in accordance with state and federal requirements.

(3) The department must consider options of realigning the TSA with another RAC to continue services.

(h) The department has the authority to schedule conferences, in-person or virtual, with 10-calendar days advanced notice, to review, inspect, evaluate, and audit all RAC documents to validate the department RAC performance criteria are met.

(i) RACs must maintain virtual options for stakeholder participation in committees or other activities.

§157.125. Requirements for Trauma Facility Designation Effective Through August 31, 2025.

(a) The Emergency Medical Services (EMS)/Trauma Systems Section recommends to the Commissioner of the Department of State Health Services (commissioner) the designation of an applicant facility (facility) as a trauma facility at the level for each location of a facility the department deems appropriate. Trauma designation surveys conducted on or before August 31, 2025, are evaluated on the requirements of this section. For surveys conducted on or after September 1, 2025, see §157.126 of this subchapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025) for the requirements.

(1) Comprehensive (Level I) trauma facility designation--The facility, including a free-standing children's facility, meets the current American College of Surgeons (ACS) essential criteria for a verified Level I trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate Regional Advisory Council (RAC); has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(2) Major (Level II) trauma facility designation--The facility, including a free-standing children's facility, meets the current ACS essential criteria for a verified Level II trauma center; meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(3) Advanced (Level III) trauma facility designation--The facility meets the "Advanced Trauma Facility Criteria" in subsection (x) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry. A free-standing children's facility, in addition to meeting the requirements listed in this section, must meet the current ACS essential criteria for a verified Level III trauma center.

(4) Basic (Level IV) trauma facility designation--The facility meets the "Basic Trauma Facility Criteria" in subsection (y) of this section; actively participates on the appropriate RAC; has appropriate services for dealing with stressful events available to emergency/trauma care providers; and submits data to the State Trauma Registry.

(b) A health care facility is defined in this subchapter as a single location where inpatients receive hospital services or each location if there are multiple buildings where inpatients receive hospital services and are covered under a single hospital license. Each location is considered separately for designation and the department will determine the designation level for that location, based on, but not limited to, the location's own resources and levels of care capabilities; Trauma Service Area (TSA) capabilities; and the essential criteria and requirements outlined in subsection (a)(1) - (4) of this section. The final determination of the level of designation may not be the level requested by the facility.

(c) The designation process consists of three phases.

(1) First phase--The application phase begins with submitting to the department a timely and sufficient application for designation as a trauma facility and ends when the survey report is received by the department.

(2) Second phase--The review phase begins with the department's review of the survey report and ends with its recommendation to the commissioner whether to designate the facility and at what level. This phase also includes an appeal procedure governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(3) Third phase--The final phase begins with the commissioner reviewing the recommendation and ends with the commissioner's final decision.

(d) For a facility seeking initial designation, a timely and sufficient application must include:

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered, or sent by postal services to the department;

(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the department;

(4) a trauma designation survey completed within one year of the date of the receipt of the application by the department; and

(5) a complete survey report, including patient care reviews, that is within 90 days of the date of the survey and is submitted to the department.

(e) If a hospital seeking initial designation fails to meet the requirements in subsection (d)(1) - (5) of this section, the application is denied.

(f) For a facility seeking re-designation, a timely and sufficient application must include:

(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, submitted to the department one year before the expiration of the current designation;

(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the department; and

(4) a complete survey report, including patient care reviews, that is within 90 days of the date of the survey and is submitted to the department and at least 60 days before the expiration of the current designation.

(g) If a health care facility seeking re-designation fails to meet the requirements outlined in subsection (f)(1) - (4) of this section, the original designation will expire on its expiration date.

(h) The department's analysis of the submitted "Complete Application" form may result in recommendations for corrective action when deficiencies are noted and must include a review of:

(1) the evidence of current participation in RAC and regional trauma and emergency health care system planning; and

(2) the completeness and appropriateness of the application materials submitted, including the submission of a non-refundable application fee as follows:

(A) for Level I and Level II trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $5,000 and a lower limit of $4,000;

(B) for Level III trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $2,500 and a lower limit of $1,500; and

(C) for Level IV trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $1000 and a lower limit of $500.

(i) When a "Complete Application" form for initial designation or re-designation from a facility is received, the department will determine the level it deems appropriate for pursuit of designation or re-designation for each facility location based on: the facility's resources and levels of care capabilities, TSA resources, and the essential criteria for Levels I, II, III, and IV trauma facilities. In general, physician services capabilities described in the application must be in place 24-hours a day/7 days a week. In determining whether a physician services capability is present, the department may use the concept of substantial compliance that is defined as having said physician services capability at least 90% of the time.

(1) If a facility disagrees with the level determined by the department to be appropriate for pursuit of designation or re-designation, it may make an appeal in writing within 60 days to the EMS/Trauma Systems Section director. The written appeal must include a signed letter from the facility's governing board with an explanation as to why designation at the level determined by the department would not be in the best interest of the citizens of the affected TSA or the citizens of the State of Texas.

(2) If the department upholds its original determination, the EMS/Trauma Systems Section director will give written notice of such to the facility within 30 days of its receipt of the applicant's complete written appeal.

(3) The facility may, within 30 days of the department sending written notification of its denial, submit a written request for further review. Such written appeal is submitted to the associate commissioner, Consumer Protection Division.

(j) When the analysis of the "Complete Application" form results in acknowledgement by the department that the facility is seeking

an appropriate level of designation or re-designation, the facility may then contract for the survey, as follows.

(1) Level I and II facilities and all free-standing children's facilities must request a survey through the ACS trauma verification program.

(2) Level III facilities must request a survey through the ACS trauma verification program or through a department-approved survey organization.

(3) Level IV facilities must request a survey through a department-approved survey organization, or by a department-credentialed surveyor.

(4) The facility must notify the department of the date of the planned survey and the composition of the survey team.

(5) The facility is responsible for any expenses associated with the survey.

(6) The department, at its discretion, may appoint a designation coordinator to accompany the survey team. In this event, the cost for the designation coordinator is borne by the department.

(k) The survey team composition must be as follows.

(1) Level I or Level II facilities must be surveyed by a team that is multidisciplinary and includes at a minimum: two general surgeons, an emergency physician, and a trauma nurse all active in the management of trauma patients.

(2) Free-standing children's facilities of all levels must be surveyed by a team consistent with current ACS policy and includes at a minimum: a pediatric surgeon, a general surgeon, a pediatric emergency physician, and a pediatric trauma nurse coordinator or a trauma nurse coordinator with pediatric experience.

(3) Level III facilities must be surveyed by a team that is multidisciplinary and includes at a minimum: a trauma surgeon and a trauma nurse (ACS or department-credentialed), both active in the management of trauma patients.

(4) Level IV facilities must be surveyed by a department-credentialed representative, registered nurse, or licensed physician. A second surveyor may be requested by the facility or by the department.

(5) Department-credentialed surveyors must meet the following criteria:

(A) have at least three years' experience in the care of trauma patients;

(B) be currently employed in the coordination of care for trauma patients;

(C) have direct experience in the preparation for and successful completion of trauma facility verification or designation;

(D) have successfully completed a department-approved trauma facility site surveyor course and be successfully re-credentialed every four years; and

(E) have current credentials as follows:

(i) for nurses: Trauma Nurses Core Course (TNCC) or Advanced Trauma Course for Nurses (ATCN); and Pediatric Advanced Life Support (PALS) or Emergency Nurses Pediatric Course (ENPC);

(ii) for physicians: Advanced Trauma Life Support (ATLS); and

(iii) have successfully completed a site survey internship.

(6) All members of the survey team, except department staff, must come from a TSA outside the facility's location and at least 100 miles from the facility. There must be no business or patient care relationship or any potential conflict of interest between the surveyor or the surveyor's place of employment and the facility being surveyed.

(l) The survey team evaluates the facility's compliance with the designation criteria, by:

(1) reviewing medical records; staff rosters and schedules; process improvement committee meeting minutes; and other documents relevant to trauma care;

(2) reviewing equipment and the physical plant;

(3) conducting interviews with facility personnel;

(4) evaluating compliance with participation in the State Trauma Registry; and

(5) evaluating appropriate use of telemedicine capabilities where applicable.

(m) The site survey report in its entirety must be part of a facility's performance improvement program and subject to confidentiality as articulated in the Texas Health and Safety Code §773.095.

(n) The surveyor must provide the facility with a written, signed survey report regarding the evaluation of the facility's compliance with trauma facility criteria. This survey report must be forwarded to the facility within 30 calendar days of the completion date of the survey. The facility is responsible for forwarding a copy of this report to the department if it intends to continue the designation process.

(o) The department must review the findings of the survey report for compliance with trauma facility criteria.

(1) A recommendation for designation must be made to the commissioner based on meeting the designation requirements.

(2) If a facility does not meet the criteria for the level of designation deemed appropriate by the department, the department must notify the facility of the requirements it must meet to achieve the appropriate level of designation.

(3) If a facility does not meet the requirements, the department must notify the facility of deficiencies and recommend corrective action.

(A) The facility must submit to the department a report that outlines the corrective action taken. The department may require a second survey to ensure compliance with the criteria. If the department substantiates action that brings the facility into compliance with the criteria, the department recommends designation to the commissioner.

(B) If a facility disagrees with the department's decision regarding its designation application or status, it may request a secondary review by a designation review committee. Membership on a designation review committee will:

(i) be voluntary;

(ii) be appointed by the EMS/Trauma Systems Section director;

(iii) be representative of trauma care providers and appropriate levels of designated trauma facilities; and

(iv) include representation from the department and the Trauma Systems Committee of the Governor's EMS and Trauma Advisory Council (GETAC).

(C) If a designation review committee disagrees with the department's recommendation for corrective action, the records must be referred to the associate commissioner for recommendation to the commissioner.

(D) If a facility disagrees with the department's recommendation at the end of the secondary review, the facility has a right to a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(p) The facility has the right to withdraw its application at any time before being recommended for trauma facility designation by the department.

(q) If the associate commissioner concurs with the recommendation to designate, the facility receives a letter and a certificate of designation valid for three years. Additional actions, such as a site review or submission of information/reports to maintain designation, may be required by the department.

(r) It is necessary to repeat the designation process as described in this section prior to expiration of a facility's designation or the designation expires.

(s) A designated trauma facility must comply with the provisions of this chapter; all current state and system standards as described in this chapter; all policies, protocols, and procedures as set forth in the system plan; and meet the following requirements.

(1) Continue its commitment to provide the resources, personnel, equipment, and response as required by its designation level.

(2) Participate in the State Trauma Registry. Data submission requirements for designation purposes are as follows.

(A) Initial designation--Six months of data prior to the initial designation survey must be uploaded. Subsequent to initial designation, data should be uploaded to the State Trauma Registry on at least a quarterly basis (with monthly submissions recommended) as indicated in Chapter 103 of this title (relating to Injury Prevention and Control).

(B) Re-designation--The facility's trauma registry should be current with at least quarterly uploads of data to the State Trauma Registry (monthly submissions recommended) as indicated in Chapter 103 of this title.

(3) Notify the department, its RAC, and other affected RACs of all changes that affect air medical access to designated landing sites.

(A) Non-emergent changes must be implemented no earlier than 120 days after a written notification process.

(B) Emergency changes related to safety may be implemented immediately along with immediate notification to department, the RAC, and appropriate air medical providers.

(C) Conflicts relating to helipad air medical access changes must be negotiated between the facility and the EMS provider.

(D) Any unresolved issues must be managed utilizing the nonbinding alternative dispute resolution (ADR) process of the RAC in which the helipad is located.

(4) Within five days, notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in if temporarily unable to comply with a designation. If the health care facility intends to meet the requirements and maintain current designation status, it must also submit to the department a plan for corrective action and a request for a temporary exception to requirements within five days.

(A) If the requested essential requirements exception is not critical to the operations of the health care facility's trauma program and the department determines the facility has intent to meet the requirements, a 30-day to 90-day exception period from the onset date of the deficiency may be granted for the facility to meet requirements.

(B) If the requested essential requirements exception is critical to the operations of the health care facility's trauma program and the department determines the facility has intent to meet requirements, no greater than a 30-day exception period from the onset date of the deficiency may be granted for the facility to meet requirements. Essential requirements that are critical include:

(i) neurological surgery capabilities (Level I, II);

(ii) orthopedic surgery capabilities (Level I, II, III);

(iii) general/trauma surgery capabilities (Level I, II, III);

(iv) anesthesiology (Levels I, II, III);

(v) emergency physicians (all levels);

(vi) trauma medical director (all levels);

(vii) trauma program manager (all levels); and

(viii) trauma registry (all levels).

(C) If the health care facility has not met the requirements at the end of the exception period, the department may at its discretion elect one of the following.

(i) Allow the facility to request designation at the level appropriate to its revised capabilities.

(ii) Propose to re-designate the facility at the level appropriate to its revised capabilities.

(iii) Propose to suspend the facility's designation status. If the facility is amenable to this action, the department will develop a corrective action plan for the facility and a specific timeline for the facility to meet the requirements.

(iv) Propose to extend the facility's temporary exception to criteria for an additional period not to exceed 90 days. The department will develop a corrective action plan for the facility and a specific timeline for the facility to meet the requirements.

(I) Suspensions of a facility's designation status and exceptions to criteria for facilities are documented on the EMS Trauma Systems Section website.

(II) If the facility disagrees with a proposal by the department or is unable or unwilling to meet the department-imposed timelines for completion of specific actions plans, it may request a secondary review by a designation review committee as defined in subsection (o)(3)(B) of this section.

(III) The department may at its discretion choose to activate a designation review committee at any time to solicit technical advice regarding criteria deficiencies.

(IV) If the designation review committee disagrees with the department's recommendation for corrective actions, the case is referred to the associate commissioner for recommendation to the commissioner.

(V) If a facility disagrees with the department's recommendation at the end of the secondary review process, the facility has a right to a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(VI) Designated trauma facilities seeking exceptions to essential criteria have the right to withdraw the request at any time prior to resolution of the final appeal process.

(5) Notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in if it no longer provides trauma services commensurate with its designation level.

(A) If the facility chooses to apply for a lower level of trauma designation, it may do so at any time; however, it is necessary to repeat the designation process. There must be a review by the department to determine if a full survey is required.

(B) If the facility chooses to relinquish its trauma designation, it must provide at least 30 days' notice to the RAC and the department.

(6) Within 30 days, notify the department; its RAC and other affected RACs; and the health care facilities to which it customarily transfers-out trauma patients or from which it customarily receives trauma transfers-in, of the change if it adds capabilities beyond those that define its existing trauma designation level.

(A) It is necessary to repeat the trauma designation process.

(B) There must be a review by the department to determine if a full survey is required.

(t) Any facility seeking trauma designation must have measures in place that define the trauma patient population managed at the facility or at each of its locations, and the ability to track trauma patients throughout the course of care within the facility or at each of its locations to maximize funding opportunities for uncompensated care.

(u) A health care facility may not use the terms "trauma facility," "trauma hospital," "trauma center," or similar terminology in its signs or advertisements or in the printed materials and information it provides to the public unless the health care facility is currently designated as a trauma facility according to the process described in this section.

(v) The department has the right to review, inspect, evaluate, and audit all trauma patient records, trauma performance improvement committee minutes, and other documents relevant to trauma care in any designated trauma facility or applicant facility at any time to verify meeting requirements in the statute and this section, including the designation requirements. The department maintains confidentiality of such records to the extent authorized by the Texas Public Information Act, Texas Government Code Chapter 552, and consistent with current laws and regulations related to the Health Insurance Portability and Accountability Act of 1996. Such inspections must be scheduled by the department when deemed appropriate. The department provides a copy of the survey report, for surveys conducted by or contracted for the department, and the results to the health care facility.

(w) The department may grant an exception to this section if it finds meeting requirements in this section would not be in the best interests of the persons served in the affected local system.

(x) Advanced (Level III) Trauma Facility Requirements. An advanced trauma facility (Level III) provides resuscitation, stabilization, and assessment of injured patients and either provides treatment or arranges for appropriate transfer to a higher level designated trauma facility.

(1) The facility must identify a trauma medical director (TMD) responsible for the provision of trauma care and must have a defined job description and organizational chart delineating the TMD's role and responsibilities. The TMD must be a physician who meets the following:

(A) is a general surgeon;

(B) is currently credentialed in ATLS or an equivalent department-approved course;

(C) is charged with overall management of trauma services provided by the
facility;

(D) must have the authority and responsibility for the clinical oversight of the trauma program, including:

(i) credentialing of medical staff who provide trauma care;

(ii) recommending trauma team privileges;

(iii) providing trauma care;

(iv) developing trauma management guidelines;

(v) collaborating with nursing to address educational needs; and

(vi) developing, implementing, and maintaining the trauma performance improvement and patient safety (PIPS) plan with the trauma program manager (TPM);

(E) must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must:

(i) have current board-certification or board-eligibility;

(ii) complete nine hours of trauma-related continuing medical education per year;

(iii) comply with trauma management guidelines; and

(iv) participate in the trauma PIPS program;

(F) must participate in a leadership role in the facility, community, and emergency management (disaster) response committee; and

(G) should participate in the development of the regional trauma system plan.

(2) An identified TPM is a registered nurse and must:

(A) successfully complete and remain current in the TNCC or ATCN or an equivalent department-approved course;

(B) successfully complete and remain current in a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC);

(C) have the authority and responsibility to monitor trauma patient care from emergency department (ED) admission

through operative intervention, intensive care unit (ICU) care, stabilization, rehabilitation care, and discharge, including the trauma PIPS program;

(D) have a defined job description and organizational chart delineating the TPM's role and responsibilities;

(E) participate in a leadership role in the facility, community, and regional emergency management (disaster) response committee;

(F) be full-time; and

(G) complete a course designed for their role that provides essential information on the structure, process, organization, and administrative responsibilities of a PIPS program to include a department-approved trauma outcomes and performance improvement course.

(3) The trauma program must have written trauma management guidelines, developed with approval by the trauma multidisciplinary committee and facility's medical staff with evidence of implementation, for:

(A) trauma team activation;

(B) trauma resuscitation guidelines for the roles and responsibilities of team members during a resuscitation;

(C) triage, admission, and transfer of trauma patients; and

(D) trauma management guidelines specific to the trauma population managed by the facility as defined by the State Trauma Registry.

(4) All major, severe, and critical trauma patients must be admitted to an appropriate surgeon and all multi-system trauma patients must be admitted to a general surgeon.

(5) A general surgeon participating in trauma-call coverage must:

(A) be credentialed in ATLS or an equivalent department-approved course at least one time if board-certification maintained; and

(B) be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) current board-certification or board-eligibility, or must maintain current ATLS or an equivalent department-approved course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines;

(iv) participation in the trauma PIPS program; and

(v) attendance at 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(6) A non-board-certified general surgeon desiring inclusion in a facility's trauma program must meet the ACS guidelines as specified in its most current version of the "Resources for Optimal Care of the Injured Patient," Alternate Criteria section.

(7) The general surgeon must be present in the ED at the time of arrival of the highest level of trauma activation or within 30 minutes of notification of the trauma activation. This must be continuously monitored by the trauma PIPS program.

(8) In facilities with surgical residency programs, evaluation and treatment may be started by a team of surgeons that must include a post-graduate year four (PGY4) or more senior surgical resident who is a member of that facility's residency program. The attending surgeon must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present in the emergency department for the highest and secondary trauma activations, and be present at operative procedures. These must be continuously monitored by the trauma PIPS program.

(9) When the attending surgeon is not activated initially and an urgent surgical consult is necessary, the maximum response time of the attending surgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(10) There must be a published on-call schedule for obtaining general surgery care. There must be a documented system for obtaining general surgical care for situations when the attending general surgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(11) An orthopedic surgeon participating in trauma-call coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(A) current board-certification, board-eligibility, or meet ACS standards as specified in its current addition of "Resources for Optimal Care of the Injured Patient," Alternate Criteria section;

(B) compliance with trauma management guidelines; and

(C) participation in the trauma PIPS program.

(12) An orthopedic surgeon providing trauma coverage must be promptly available (physically present) at the major, severe, or critical trauma patient's bedside within 30 minutes of request by the attending trauma surgeon or emergency physician, from inside or outside the facility. This must be continuously monitored by the trauma PIPS program.

(13) When the orthopedic surgeon is not activated initially and an urgent surgical consult is necessary, the maximum response time of the orthopedic surgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(14) There must be a published on-call schedule for obtaining orthopedic surgery care. There must be a documented system for obtaining orthopedic surgery care for situations when the attending orthopedic surgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(15) The orthopedic surgeon representative to the multidisciplinary trauma committee maintains nine hours of trauma-related continuing medical education per year and attends 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(16) When a Level III facility has either full-time, routine, or limited neurosurgical coverage, a neurosurgeon participating in trauma-call coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(A) current board-certification, board-eligibility, or meet ACS standards as specified in its current addition of "Resources for Optimal Care of the Injured Patient," Alternate Criteria section;

(B) compliance with trauma management guidelines; and

(C) participation in the trauma PIPS program.

(17) A neurosurgeon providing trauma coverage must be promptly available (physically present) at the major, severe, or critical trauma patient's bedside and neurosurgical evaluation must occur within 30 minutes for the following criteria: severe traumatic brain injury (TBI) with a Glasgow coma scale (GCS) less than 9 and computed tomography (CT) evidence of TBI; moderate TBI with GCS of 9-12 and CT evidence of potential intracranial lesion; and neurological deficit produced by a potential spinal cord injury. When a neurosurgical advanced practice provider (APP) or neurosurgical resident is utilized, there must be documented evidence of consultation with the neurosurgical attending on-call prior to implementation of the plan of care. This must be continuously monitored by the trauma PIPS program, including the consult times and response times.

(18) When the neurosurgeon is not notified of the initial activation or was not consulted by the evaluating team and it has been determined by the emergency physician or trauma surgeon that an urgent neurosurgical consult is necessary, the maximum response time of the neurosurgeon is 60 minutes from notification to physical presence at the patient's bedside. This must be continuously monitored by the trauma PIPS program.

(19) There must be a published on-call schedule for obtaining neurosurgical care.

(20) There must be a documented system for obtaining neurosurgical care for situations when the neurosurgeon on-call is not available. This must be continuously monitored by the trauma PIPS program.

(21) The neurosurgeon representative to the multidisciplinary trauma committee must have nine hours of trauma-related continuing medical education per year and attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(22) An emergency physician must be available in the emergency department 24-hours a day and physicians providing trauma coverage must meet the following:

(A) be credentialed by the facility to provide emergency medical services; and

(B) be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and must maintain:

(i) current board-certification, board-eligibility, or maintain current ATLS or an equivalent department-approved course;

(ii) compliance with trauma management guidelines; and

(iii) participation in the trauma PIPS program.

(23) A board-certified emergency medicine physician providing trauma coverage must have successfully completed an ATLS Student Course or an equivalent department-approved ATLS course at least once.

(24) Current ATLS verification is required for all physicians who work in the emergency department and are not board-certified in Emergency Medicine.

(25) The emergency physician representative to the multidisciplinary trauma committee must have nine hours of trauma-related continuing medical education per year and attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(26) The radiology physician on-call must respond within 30 minutes of request, from inside or outside the facility. This system must be continuously monitored by the trauma PIPS program.

(27) The anesthesiology physician on-call must respond within 30 minutes of request, from inside or outside the facility. This system must be continuously monitored by the trauma PIPS program.

(A) Requirements may be fulfilled by a member of the anesthesia care team credentialed by the TMD to participate in the resuscitation and treatment of trauma patients that may include:

(i) current board certification or board eligibility;

(ii) trauma continuing education;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) The anesthesiology physician representative to the multidisciplinary trauma committee that provides trauma coverage to the facility must attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(28) All nurses caring for trauma patients throughout the continuum of care have ongoing documented knowledge and skill in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.

(29) Written guidelines for nursing care of trauma patients for all units (e.g., ED, ICU, Operating Room (OR), Post Anesthesia Care Unit (PACU), Medical/Surgical Units) in the facility must be implemented.

(30) The facility must have a written plan, developed by the facility, for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, and multiple emergency procedures and admissions (i.e., a written disaster plan.)

(31) The facility must have emergency services available 24-hours a day.

(A) The ED must have a designated physician director.

(B) The ED must have physicians with special competence in the care of critically injured patients, designated as members of the trauma team, and physically present in the ED 24-hours per day. Neither a facility's telemedical capabilities nor the physical presence of advanced practice providers (APPs) satisfies this requirement.

(C) APPs who participate in trauma patient resuscitations and telemedicine-support physicians who participate in the care of major, severe, or critical trauma patients must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) board-certification or board-eligibility in specialty, or current ATLS or an equivalent department-approved ATLS course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(D) The ED physician must be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private vehicle for the highest level of trauma activation and must respond within 30 minutes from notification of the

trauma activation. This must be monitored in the trauma PIPS program.

(E) A minimum of two registered nurses who have trauma nursing training must participate in the highest level trauma activations.

(F) All registered nursing staff responding to the highest levels of trauma activations must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., Advanced Cardiac Life Support (ACLS) or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course. A free-standing children's facility is exempt from the ACLS requirement.

(G) Nursing documentation for trauma activation patients must be systematic and meet the trauma primary and secondary assessment guidelines.

(H) 100 percent of nursing staff must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(I) 100 percent of a free-standing children's facility nursing staff who care for trauma patients must have successfully completed and hold current credentials in a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC) and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(J) Two-way communication with all pre-hospital emergency medical services vehicles must be available.

(K) Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages must include:

(i) airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, bag-valve-mask devices (BVMs), pocket masks, advanced airway management devices, and oxygen;

(ii) mechanical ventilator;

(iii) pulse oximetry and capnography;

(iv) suction device;

(v) electrocardiograph, oscilloscope, and defibrillator;

(vi) internal age-specific paddles;

(vii) all standard intravenous fluids and administration devices, including large-bore intravenous catheters and a rapid infuser system;

(viii) sterile surgical sets for procedures standard for the emergency department such as thoracostomy, venous cutdown, central line insertion, thoracotomy, diagnostic peritoneal lavage (if performed at facility), airway control/cricothyrotomy, etc.;

(ix) drugs and supplies necessary for emergency care;

(x) cervical spine stabilization device;

(xi) length-based body weight and tracheal tube size evaluation system (e.g., a current Broselow tape) and resuscitation medications and equipment that are dose-appropriate for all ages;

(xii) long bone stabilization device;

(xiii) pelvic stabilization device;

(xiv) thermal control equipment for patients and a rapid warming device for blood and fluids; and

(xv) non-invasive continuous blood pressure monitoring devices.

(32) Imaging capability must be available, with an in-house technician 24-hours a day or on-call and responding within 30 minutes of request. This must be continuously monitored by the trauma PIPS program.

(33) Psychosocial support services must be available for staff, patients, and their families.

(34) Operating room services must be available 24-hours a day.

(A) With advanced notice, the operating room must be opened and ready to accept a patient within 30 minutes. This must be continuously monitored by the trauma PIPS program.

(B) Equipment for all trauma patient populations and anticipated special requirements must include:

(i) thermal control equipment for patient and for blood and fluids;

(ii) imaging capability including c-arm image intensifier with technologist available 24-hours a day;

(iii) endoscopes, all varieties, and bronchoscope;

(iv) equipment for long bone and pelvic fixation;

(v) rapid infuser system;

(vi) appropriate monitoring and resuscitation equipment;

(vii) capability to measure pulmonary capillary wedge pressure; and

(viii) capability to measure invasive systemic arterial pressure.

(35) A PACU or surgical ICU must be available for trauma patients following operative interventions and include the following.

(A) Registered nurses and other essential personnel 24-hours a day.

(B) Appropriate monitoring and resuscitation equipment.

(C) Pulse oximetry and capnography.

(D) Thermal control equipment for patients and a rapid warming device for blood and fluids.

(36) An ICU must be available for trauma patients 24-hours a day and include the following.

(A) Designated surgical director or surgical co-director responsible for setting policies and administration related to trauma ICU patients. A physician providing this coverage must be a surgeon credentialed by the TMD to participate in the resuscitation and treatment of trauma patients and must maintain:

(i) board-certification, board-eligibility, or current in ATLS or an equivalent department-approved course;

(ii) trauma continuing medical education;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) Physician, credentialed in critical care by the TMD, on duty in ICU 24-hours a day or immediately available from in-facility. Arrangements for 24-hour surgical coverage of all trauma patients must be provided for emergencies and routine care. This must be continuously monitored by the trauma PIPS program.

(C) Registered nurse-patient minimum ratio of 1:2 on each shift for patients identified as critical acuity.

(D) Appropriate monitoring and resuscitation equipment.

(E) Pulse oximetry and capnography.

(F) Thermal control equipment for patients and a rapid warming device for blood and fluids.

(G) Capability to measure pulmonary capillary wedge pressure.

(H) Capability to measure invasive systemic arterial pressure.

(37) Respiratory services in-house and must be available 24-hours per day.

(38) Clinical laboratory services must be available 24-hours per day and provide the following.

(A) Standard analyses of blood, urine, and other body fluids, including microsampling.

(B) Blood typing and cross-matching, to include massive transfusion guidelines and emergency release of blood guidelines.

(C) Comprehensive blood bank or access to a community central blood bank and adequate facility storage.

(D) Coagulation studies.

(E) Blood gases and pH determinations.

(F) Microbiology.

(G) Drug and alcohol screening.

(H) Infectious disease standard operating procedures.

(I) Serum and urine osmolality.

(39) Special imaging capabilities must be available.

(A) Sonography is available 24-hours per day or on-call and if notified, responds within 30 minutes of notification.

(B) Computerized tomography (CT) is available on-call 24-hours per day and if notified, responds within 30 minutes. This must be continuously monitored by the trauma PIPS program.

(C) Angiography of all types is available 24-hours per day and if on-call, responds within 30 minutes.

(D) Nuclear scanning is available and responds as defined in the trauma management guidelines.

(40) Acute hemodialysis capability is available or transfer agreements are documented if not available.

(41) Established criteria for care of burn patients with a process to expedite the transfer of burn patients to a burn center or higher level of care.

(42) In circumstances where a designated spinal cord injury rehabilitation center exists in the region, early transfer should be considered and transfer agreements in effect.

(43) In circumstances where a moderate to severe head injury center exists in the region, transfer should be considered in selected patients and transfer agreements in effect.

(44) Physician-directed rehabilitation service, staffed by personnel trained in rehabilitation care and properly equipped for care of the injured patient, or transfer guidelines to a rehabilitation facility for patients needing a higher level of care or specialty services, including:

(A) physical therapy;

(B) occupational therapy; and

(C) speech therapy.

(45) Social services must be available to assist with management of trauma patients.

(46) The facility must have a defined trauma PIPS plan approved by the TMD, TPM, and the multidisciplinary committee.

(A) On initial designation, a facility must have completed at least six months of reviews on all qualifying trauma records with evidence of "loop closure" on identified variances. Compliance with internal trauma management guidelines must be evident.

(B) On re-designation, a facility must show continuous PIPS activities throughout its designation and a rolling current three-year period must be available for review at all times.

(C) Minimum PIPS inclusion criteria must include: all trauma team activations (including those discharged from the ED); all trauma deaths; all identified facility events; transfers-in and transfers-out; and readmissions within 48 hours after discharge.

(D) The trauma PIPS program must be organized and include a pediatric-specific component with trauma audit filters.

(i) Review of trauma medical records for appropriateness and quality of care.

(ii) Documented evidence of identification of all variances from trauma management guidelines and system response guidelines, with in-depth critical review.

(iii) Documented evidence of corrective actions implemented to address all identified variances with tracking of data analysis.

(iv) Documented evidence of secondary level of review and participation by the TMD.

(v) Morbidity and mortality review including decisions by the TMD as to whether the trauma management guidelines were followed.

(vi) Documented resolutions "loop closure" of all identified variance to prevent future recurrences.

(vii) Specific reviews of all trauma deaths and other specified cases, including complications, utilizing age-specific criteria.

(viii) Multidisciplinary hospital trauma PIPS committee structure in place.

(E) Multidisciplinary trauma committee meetings for PIPS activities must include department communication, data review, and measures for problem solving.

(F) Multidisciplinary trauma conferences must include all disciplines caring for trauma patients. This conference must be for the purpose of addressing PIPS activities and continuing education.

(G) Feedback regarding trauma patient transfers-in must be provided to all transferring facilities.

(H) Feedback regarding trauma patient transfers-out must be obtained from receiving facilities.

(I) The trauma program must maintain a trauma registry or utilize the State Trauma Registry for data entry of NTDB registry inclusion criteria patients. Trauma registry data must be submitted to the State Trauma Registry on at least a quarterly basis.

(J) The trauma program must participate in the RAC's performance improvement (PI) program, including adherence to regional guidelines, submitting data preapproved by the RAC membership such as summaries of transfer delays and transfers to facilities outside of the RAC.

(K) The trauma program must track the times and reasons for diversion must be documented and reviewed by the trauma PIPS program and multidisciplinary committee.

(L) The trauma program must maintain published on-call schedules must be maintained for general surgeons, orthopedic surgeons, neurosurgeons, anesthesia, radiology, and other major specialists, if available.

(M) The trauma program must have performance improvement personnel dedicated to and specific for the trauma program.

(47) The trauma program must participate in the regional trauma system per RAC requirements.

(48) The trauma program must have a process to expedite the transfer of major, severe, or critical trauma patients to include written management guidelines, written transfer agreements, and participation in a regional trauma system transfer plan for patients needing higher level of care or specialty services.

(49) The facility must have a system for establishing an appropriate landing zone near the facility (if rotor-wing services are available).

(50) The trauma program must provide education and consultations to physicians of the community and outlying areas.

(51) The trauma program must have an identified individual to coordinate the facility's community outreach programs for the public and professionals.

(52) The trauma program must have a public education program to address specific injuries identified by the facility's trauma registry. Documented participation in a RAC injury prevention program is acceptable.

(53) The trauma program must have formal programs in trauma continuing education provided by facility for staff or in collaboration with the RAC, based on needs identified from the trauma PIPS program for:

(A) staff physicians;

(B) nurses;

(C) allied health personnel, including advanced practice providers;

(D) community physicians; and

(E) pre-hospital personnel.

(54) The facility may participate in trauma-related research.

(y) Basic (Level IV) Trauma Facility Requirements. A Basic Trauma Facility (Level IV) provides resuscitation, stabilization, and arranges for appropriate transfer of trauma patients requiring a higher level of definitive care.

(1) The facility must identify a TMD responsible for the provision of trauma care and must have a defined job description and organizational chart delineating the TMD's role and responsibilities. The TMD must be a physician who meets the following:

(A) is currently credentialed in ATLS or an equivalent department-approved course;

(B) is charged with overall management of trauma services provided by the facility;

(C) must have the authority and responsibility for the clinical oversight of the trauma program, including:

(i) credentialing of medical staff who provide trauma care;

(ii) providing trauma care;

(iii) developing trauma management guidelines;

(iv) collaborating with nursing to address educational needs; and

(v) developing and implementing the trauma PIPS plan with the TPM;

(D) must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients and must:

(i) have current board-certification or board-eligibility in surgery, emergency medicine or family medicine, or must maintain current ATLS or an equivalent department-approved course;

(ii) complete nine hours of trauma-related continuing medical education per year;

(iii) comply with trauma management guidelines; and

(iv) participate in the trauma PIPS program;

(E) must participate in a leadership role in the facility, community, and emergency management (disaster) response committee; and

(F) should participate in the development of the regional trauma system plan.

(2) An identified TPM is a registered nurse and must:

(A) successfully complete and remain current in the TNCC or ATCN or an equivalent department-approved course;

(B) successfully complete and remain current in a nationally recognized pediatric advanced life support course (e.g., PALS or the ENPC);

(C) have the authority and responsibility to monitor trauma patient care from ED admission through operative intervention, ICU care, stabilization, rehabilitation care, and discharge, including the trauma PIPS program;

(D) have a defined job description and organizational chart delineating the TPM's role and responsibilities;

(E) participate in a leadership role in the facility, community, and regional emergency management (disaster) response committee;

(F) ensure the TPM hours dedicated to the trauma program maintains a concurrent PIPS process and trauma registry; and

(G) complete a course designed for their role that provides essential information on the structure, process, organization, and administrative responsibilities of a PIPS program to include a department-approved trauma outcomes and performance improvement course.

(3) An identified Trauma Registrar or TPM must have appropriate training (e.g., the Association for the Advancement of Automotive Medicine (AAAM) course) in injury severity scaling. Typically, one full-time equivalent (FTE) employee dedicated to the registry is required to process approximately 500 patients annually.

(4) Written trauma management guidelines must be developed with approval by the TMD, TPM, and the facility's medical staff with evidence of implementation, for:

(A) trauma team activation, including defined response times;

(B) trauma resuscitation, defining the roles and responsibilities of team members during a resuscitation;

(C) triage, admission, and transfer of trauma patients; and

(D) trauma management specific to the trauma population managed by the facility as defined by the trauma registry.

(5) The emergency department must have physician coverage 24-hours per day. The physician providing coverage in the ED must be credentialed by the facility to provide emergency medical services.

(A) A physician providing trauma coverage must be credentialed by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and must maintain:

(i) current board-certification or board-eligibility in emergency medicine or family medicine, or current ATLS or an equivalent department-approved course;

(ii) nine hours of trauma-related continuing medical education per year;

(iii) compliance with trauma management guidelines; and

(iv) participation in the trauma PIPS program.

(B) A board-certified emergency medicine physician providing trauma coverage must have successfully completed an ATLS Student Course or an equivalent department-approved ATLS course, at least once.

(C) Current ATLS verification is required for all physicians who work in the ED and are not board-certified in emergency medicine.

(D) The emergency physician representative to the multidisciplinary committee that provides trauma coverage to the facility must attend 50 percent or more of multidisciplinary and peer review trauma committee meetings.

(6) Radiology physician services must be available.

(7) Anesthesiology may be fulfilled by a member of the anesthesia care team credentialed in assessing emergent situations in trauma patients and providing any indicated treatment if operative services are provided.

(8) All nurses caring for trauma patients throughout the continuum of care must have ongoing documented knowledge and skill in trauma nursing for patients of all ages to include trauma specific orientation, annual clinical competencies, and continuing education.

(9) Written guidelines for nursing care of trauma patients for all units (i.e., ED, ICU, OR, PACU, medical/surgical units) in the facility must be implemented.

(10) The facility must have a written plan, developed by the facility, for acquisition of additional staff on a 24-hour basis to support units with increased patient acuity, multiple emergency procedures, and admissions (i.e., written disaster plan.)

(11) The facility must have emergency services available 24-hours a day.

(A) Physician on-call schedule must be published.

(B) Physicians with special competence in the care of critically injured patients, designated as members of the trauma team and on-call (if not in-house 24/7) must be promptly available within 30 minutes of request from inside or outside the facility. Neither a facility's telemedicine medical service capabilities nor the physical presence of APPs satisfy this requirement with the exception of the following:

(i) A health care facility located in a county with a population of less than 30,000 may satisfy a Level IV trauma facility designation requirement relating to physicians through the use of telemedicine medical service in which an on-call physician who has special competence in the care of critically injured patients provides patient assessment, diagnosis, consultation, or treatment, or transfers medical data to a physician, advanced practice registered nurse, or physician assistants located at the facility; and

(ii) APPs and telemedicine-support physicians who participate in the care of major, severe, or critical trauma patients must be credentialed by the facility to participate in the resuscitation and treatment of trauma patients, to include requirements such as current board-certification or board-eligibility in surgery or emergency medicine, nine hours of trauma-related continuing medical education per year, compliance with trauma management guidelines, and participation in the trauma PIPS program.

(C) The ED physician must be activated on EMS communication with the ED or after a primary assessment of patients who arrive to the ED by private vehicle for the highest level of trauma activation and must respond within 30 minutes from notification. This must be continuously monitored in the trauma PIPS program.

(D) A minimum of one and preferably two registered nurses who have trauma nursing training must participate in initial resuscitation of the highest level of trauma activations.

(E) All registered nursing staff responding to the highest levels of trauma activations must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g., PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course.

(F) 100 percent of nursing staff must have successfully completed and hold current credentials in an advanced cardiac life support course (e.g., ACLS or an equivalent department-approved course), a nationally recognized pediatric advanced life support course (e.g.,

PALS or ENPC), and TNCC or ATCN or an equivalent department-approved course, within 18 months of date of employment in the ED.

(G) Nursing documentation for trauma activation patients must be systematic and meet the trauma primary and secondary assessment guidelines.

(H) Two-way communication with all pre-hospital emergency medical services vehicles must be available.

(I) Equipment and services for the evaluation and resuscitation of, and to provide life support for, critically or seriously injured patients of all ages must include:

(i) airway control and ventilation equipment including laryngoscope and endotracheal tubes of all sizes, BVMs, pocket masks, advanced airway management devices, and oxygen;

(ii) mechanical ventilator;

(iii) pulse oximetry and capnography;

(iv) suction device;

(v) electrocardiograph, oscilloscope, and defibrillator;

(vi) all standard intravenous fluids and administration devices, including large-bore intravenous catheters and a rapid infuser system;

(vii) sterile surgical sets for procedures standard for the ED such as thoracostomy, central line insertion, thoracotomy if surgeons participate in trauma care, airway control/cricothyrotomy, etc.;

(viii) drugs and supplies necessary for emergency care;

(ix) cervical spine stabilization device;

(x) length-based body weight & tracheal tube size evaluation system (e.g., a current Broselow tape) and resuscitation medications and equipment that are dose-appropriate for all ages;

(xi) long bone stabilization device;

(xii) pelvic stabilization device;

(xiii) thermal control equipment for patients and a rapid warming device for blood and fluids; and

(xiv) non-invasive continuous blood pressure monitoring devices.

(12) Clinical laboratory services must be available 24-hours per day and provide the following.

(A) Call-back process for trauma activations available within 30 minutes. This must be continuously monitored in the trauma PIPS program.

(B) Standard analyses of blood, urine, and other body fluids, including microsampling.

(C) Blood-typing and cross-matching with a minimum of two units of universal packed red blood cells (PRBCs) immediately available.

(D) Capability for immediate release of blood for a transfusion and measures to obtain additional blood supply.

(E) Coagulation studies.

(F) Blood gases and pH determinations.

(G) Drug and alcohol screening.

(13) Imaging capabilities must be available 24-hours per day. Call-back process for trauma activations must be available within 30 minutes. This must be continuously monitored in the trauma PIPS program.

(14) The trauma program must have a defined trauma PIPS plan approved by the TMD, TPM, and the trauma multidisciplinary committee.

(A) On initial designation, a facility must have completed at least six months of reviews on all qualifying trauma records with evidence of "loop closure" on identified variances. Compliance with internal trauma management guidelines must be evident.

(B) On re-designation, a facility must show continuous PIPS activities throughout its designation and a rolling current three-year period must be available for review at all times.

(C) Minimum PIPS inclusion criteria includes: all trauma team activations (including those discharged from the ED); all trauma deaths; all identified facility events; transfers-in and transfers-out; and readmissions within 48-hours after discharge.

(D) The trauma PIPS program must be organized and include a pediatric-specific component with trauma audit filters.

(i) Review of trauma medical records for appropriateness and quality of care.

(ii) Documented evidence of identification of all variances from trauma management guidelines and system response guidelines, with in-depth critical review.

(iii) Documentation of corrective actions implemented to address all identified variances with tracking of data analysis.

(iv) Documented evidence of secondary level of review and participation by the TMD.

(v) Morbidity and mortality review including decisions by the TMD as to whether the trauma management guidelines were followed.

(vi) Documented resolutions "loop closure" of all identified issues to prevent future recurrences.

(vii) Specific reviews of all trauma deaths and other specified cases, including complications, utilizing age-specific criteria.

(viii) Multidisciplinary facility trauma PIPS committee structure must be in place and include department communication, data review, and measures for problem solving.

(E) Feedback regarding trauma patient transfers-out must be obtained from receiving facilities.

(F) Facility must maintain a trauma registry or utilize the State Trauma Registry for data entry of patients meeting NTDB registry inclusion criteria. Trauma registry data must be submitted to the State Trauma Registry on at least a quarterly basis.

(G) Participation with the RAC's PI program, including adherence to regional guidelines, submitting data preapproved by the membership to the RAC such as summaries of transfer delays and transfers to facilities outside of the RAC.

(H) Times and reasons for diversion must be documented and reviewed by the trauma PIPS program and multidisciplinary committee.

(15) The trauma program must participate in the regional trauma system per RAC requirements.

(16) The trauma program must have processes in place to expedite the transfer of major, severe, or critical trauma patients to include written management guidelines, written transfer agreements, and participation in a regional trauma system transfer plan for patients needing higher level of care or specialty services.

(17) The facility must have a system in place for establishing an appropriate landing zone in close proximity to the facility (if rotor-wing services are available).

(18) Facility may participate in a RAC injury prevention program.

(19) Formal programs in trauma continuing education must be provided by the facility or in collaboration with the RAC or their health care system based on needs identified from the trauma PIPS program for:

(A) staff physicians;

(B) nurses; and

(C) allied health personnel, including APPs.

§157.126. Trauma Facility Designation Requirements Effective on September 1, 2025.

(a) The department designates hospital applicants as trauma facilities, which are part of the trauma and emergency health care system. Hospitals must meet the designation requirements specific to the level of designation requested by September 1, 2025. Trauma designation surveys conducted on or after September 1, 2025, are evaluated on the requirements in this section.

(b) The facility seeking trauma designation submits a completed designation application packet to the department. The department reviews the facility application documents for the appropriate level of designation. The complete designation application packet must include the following:

(1) a trauma designation application for the requested level of trauma designation;

(2) a completed department designation assessment questionnaire;

(3) the documented trauma designation survey summary report that includes findings of requirements met and medical record reviews;

(4) evidence of documented data validation and quarterly submission to the State Trauma Registry and National Trauma Data Bank (NTDB) (if applicable) for the past 12 months;

(5) evidence of the facility's trauma program and Trauma Medical Director (TMD) or designee participation at Regional Advisory Council (RAC) meetings throughout the designation cycle; and

(6) full payment of the non-refundable, non-transferrable designation fee.

(c) The department reviews the designation application packet to determine and approve the facility's level of trauma designation. The department defines the final trauma designation level awarded to the facility and this designation may be different than the level requested based on the designation site survey summary. If the department determines the facility meets the requirements for trauma designation the department provides the facility with a designation award letter and a designation certificate. The facility must display its trauma designation certificate in a public area of the licensed premises that is readily visible to patients, employees, and visitors.

(d) Eligibility requirements for trauma designation.

(1) Health care facilities eligible for trauma designation include:

(A) a hospital in Texas, licensed or otherwise, in accordance with Texas Health and Safety Code Chapter 241;

(B) a hospital owned and operated by the State of Texas; or

(C) a hospital owned and operated by the federal government, in Texas.

(2) Each hospital must demonstrate the capability to stabilize and transfer or treat an acute trauma patient, have written trauma management guidelines for the hospital, have a written operational plan, and have a written trauma performance improvement and patient safety (PIPS) plan.

(3) Each hospital operating on a single hospital license with multiple locations (multi-location license) may apply for trauma designation separately by physical location for each designation.

(A) Hospital departments or services within a hospital must not be designated separately.

(B) Hospital departments located in a separate building not contiguous with the designated facility must not be designated separately.

(C) Each non-contiguous emergency department of a hospital operating on a single hospital license must have trauma patient care and transfers monitored through the main hospital's trauma program.

(e) A facility is defined under subsection (d) of this section as a single location where inpatients receive hospital services and inpatient care.

(1) Each facility location must meet the requirements for designation. The department defines the designation level based on the facility's ability to demonstrate designation requirements are met.

(2) Each facility must submit a separate trauma designation application based on its resources and the level of designation the facility is seeking.

(3) If there are multiple hospitals covered under a single hospital license, each hospital or physical location where inpatients receive hospital services and care may seek designation.

(4) Trauma designation is issued for the physical location and to the legal owner of the operations of the designated facility and is non-transferable.

(f) Facilities seeking trauma designation must meet department-approved requirements and have them validated by a department-approved survey organization.

(g) The four levels of trauma designation are as follows.

(1) Comprehensive trauma facility designation (Level I). The facility, including a free-standing children's facility, must:

(A) meet the current American College of Surgeons (ACS) trauma verification standards for Level I and receive a letter of verification from the ACS;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 (relating to Injury Prevention and Control).

(2) Major trauma facility designation (Level II). The facility, including a free-standing children's facility, must:

(A) meet the current ACS trauma verification standards for Level II and receive a letter of verification from the ACS;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(3) Advanced trauma facility designation (Level III). The facility, including a free-standing children's facility, must:

(A) meet the current ACS trauma verification standards for Level III and receive a letter of verification from the ACS, or complete a designation survey conducted by a department-approved survey organization;

(B) meet the state trauma designation requirements;

(C) meet the participation requirements for the local RAC;

(D) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(E) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(4) Basic trauma facility designation (Level IV). The facility, including a free-standing children's facility:

(A) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must:

(i) meet the current ACS trauma verification standards for Level IV and complete a designation survey conducted by a department-approved survey organization;

(ii) meet the state trauma designation requirements;

(iii) meet the participation requirements for the local RAC;

(iv) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(v) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(B) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually must:

(i) meet the defined state trauma designation requirements and complete a designation survey with the department or with a department-approved survey organization;

(ii) meet the participation requirements for the local RAC;

(iii) have appropriate services for dealing with stressful events available to emergency and trauma care providers; and

(iv) submit quarterly trauma data to the State Trauma Registry, defined in Chapter 103 of this title (relating to Injury Prevention and Control).

(h) All facilities seeking trauma designation must meet the following requirements.

(1) Facilities must have documented evidence of participation in the local RAC.

(2) Facilities must have evidence of quarterly trauma data submissions to the State Trauma Registry for patients that meet NTDB registry inclusion criteria, following the National Trauma Data Standards (NTDS) definitions and state definitions.

(3) Facilities must have emergency medical services (EMS) communication capabilities.

(4) Facilities must have provisions to capture the EMS wristband number or measures for patient tracking in resuscitation documentation.

(5) Facilities must have provisions to provide and document EMS hand-off.

(6) Facilities must have landing zone capabilities or system processes to establish a landing zone (when rotor-wing capabilities are available) with appropriate staff safety training.

(7) Facilities must have a process to provide feedback to EMS providers.

(8) All levels of trauma facilities must have written trauma management guidelines specific to the hospital that align with evidence-based practices and current national standards, which must be reviewed a minimum of every three years. These guidelines must be specific to the trauma patient population managed by the facility. Guidelines must be established for the following:

(A) trauma activation and response time based on national recommendations;

(B) trauma resuscitation and documentation;

(C) consultation services requests and response;

(D) admission and transfer;

(E) screening, management, and appropriate interventions or referral for both suspected and confirmed abuse of all patient populations; and

(F) massive transfusion.

(9) Facilities must have defined documentation of trauma management guidelines pertinent to the care of trauma patients in all nursing units providing care to the trauma patient.

(10) The written trauma management guidelines must be monitored though the trauma PIPS process.

(11) The trauma program must have provisions for the availability of all necessary equipment and services to administer the appropriate level of care and support for the injured patient meeting the hospital's trauma activation guidelines and meeting NTDB registry inclusion criteria through the continuum of care to discharge or transfer.

(12) All levels of adult trauma facilities must meet and maintain the Emergency Medical Services for Children's Pediatric Readiness Criteria, as evidenced by the following:

(A) annual completion of the on-line National Pediatric Readiness Project assessment (https://pedsready.org), including a writ-

ten plan of correction (POC) for identified opportunities for improvement that is monitored through the trauma PIPS plan until resolution;

(B) pediatric equipment and resources immediately available at the facility, and staff with defined and documented competency skills and training on the pediatric equipment;

(C) education and training requirements for Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS) for the nurses responding to pediatric trauma activations;

(D) assessments and documentation include Glasgow Coma Score (GCS); complete vital signs to include temperature, heart rate, respirations, and blood pressure; pain assessment; and weight recorded in kilograms;

(E) serial vital signs, GCS, and pain assessments are completed and documented for the highest level of trauma activations or when shock, a traumatic brain injury, or multi-system injuries are identified;

(F) pediatric imaging guidelines and processes addressing pediatric age or weight-based appropriate dosing for studies imparting radiation consistent with the ALARA (as low as reasonably achievable) principle; and

(G) documented evidence the trauma facility has completed a pediatric trauma resuscitation simulation with medical staff participation every six months, including a completed critique identifying opportunities for improvement integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected. An adult trauma facility managing 200 or more patients less than 15 years of age with an injury severity score (ISS) of 9 or greater is exempt from this requirement of pediatric trauma simulations. If the facility has responded to an actual pediatric trauma resuscitation event during a six-month period, the facility is exempt from this training but must have documented evidence of participation in the after-action-review.

(13) Free-standing children's trauma facilities must have resources and equipment immediately available for adult trauma resuscitations, adherence to the nursing requirements for Trauma Nurse Core Course (TNCC) or Advanced Trauma Care for Nurses (ATCN), documented evidence the trauma program has completed an adult trauma resuscitation simulation with medical staff participation every six months, including a completed critique identifying opportunities for improvement integrated into the trauma performance improvement initiatives and tracked until the identified opportunities are corrected. Free-standing children's trauma facilities managing 200 adult patients 15 years or older with an ISS of 9 or greater are exempt from this requirement for adult trauma simulations.

(14) Rural Level IV trauma facilities in a county with a population less than 30,000 may utilize telemedicine resources with an Advanced Practice Provider (APP) available to respond to the trauma patient's bedside within 30 minutes of notification, with written resuscitation and trauma management guidelines monitored through the trauma performance improvement and patient safety processes.

(A) The APP must be current in Advance Trauma Life Support (ATLS) training, annually maintain an average nine hours of trauma-related continuing medical education, and demonstrate adherence to the trauma patient management guidelines and documentation standards.

(B) The facility must have a documented telemedicine physician credentialing process.

(C) All assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.

(15) Telemedicine in trauma facilities in a county with a population of 30,000 or more, if utilized, must have a documented physician credentialing process, written trauma protocols for utilization of telemedicine including physician response times, and measures to ensure the trauma management guidelines and evidence-based practice are monitored through the trauma performance improvement and patient safety processes.

(A) Telemedicine cannot replace the requirement for the trauma on-call physician to respond to the trauma activations in-person, to conduct inpatient rounds, or to respond to emergency requests from the inpatient units, when requested.

(B) All telemedicine assessments, physician orders, and interventions initiated through telemedicine must be documented in the patient's medical record.

(C) Telemedicine services or the telemedicine physician may be requested to assist in trauma performance improvement committee reviews.

(16) The trauma medical director (TMD) must define the role and expectations of the hospitalist or intensivist in providing care to the admitted injured patient meeting trauma activation guidelines and meeting NTDB registry inclusion criteria.

(17) A trauma program manager (TPM) or designee must be a participating member of the nurse staffing committee.

(18) The facility must maintain medical records facilitating the documentation of trauma patient arrival, level of activation, physician response and team response times, EMS hand-off, wristband number or patient tracking identifier, resuscitation, assessments, vital signs, GCS, serial evaluation of needs, interventions, patient response to interventions, reassessments, and re-evaluation through all phases of care to discharge or transfer out of the facility.

(19) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have an organized, effective trauma service recognized in the medical staff bylaws or rules and regulations and approved by the governing body. Medical staff credentialing must include a process for requesting and granting delineation of privileges for the TMD to oversee the providers participating in trauma call coverage, the trauma panel, and trauma management through all phases of care.

(20) Level I, II, and III facilities must have a TMD with requirements aligned with the current ACS standards specific to the level of designation requested and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have a TMD with a defined job description that is a surgeon, emergency medicine physician, or family practice physician that is board-certified in their specialty, current in ATLS, and meet the other ACS standards specific to the TMD for the level of designation requested. The TMD must complete a trauma performance improvement course approved by the department.

(21) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have an identified TPM responsible for monitoring trauma patient care throughout the continuum of care, from pre-hospital management to trauma activation, inpatient admission, and transfer or discharge, to include transfer follow-up as appropriate. The TPM must be a registered nurse with clinical

background in trauma care and must have completed a trauma performance improvement course approved by the department and the Association for the Advancement of Automotive Medicine (AAAM) Injury Scaling Course, and have current TNCC or ATCN, Emergency Nursing Pediatric Course (ENPC) or Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS) certifications. It is recommended for the TPM to complete courses specific to the TPM role. The role must be only for that facility and cannot cover multiple facilities. The TPM authority and responsibilities are aligned with the current ACS standards for the specific level of designation.

(22) The facility must have an organizational structure that facilitates the TPM's review of trauma care from admission to discharge, allowing for recommendations to improve care through all phases of care, and a reporting structure to an administrator having the authority to recommend and monitor facility system changes and oversee the trauma program.

(23) All levels of trauma facilities must maintain a continuous trauma PIPS plan. The plan must be data-driven and must:

(A) identify variances in care or system response events for review, including factors that led to the event, delays in care, hospital events such as complications, and all trauma deaths;

(B) define the levels of harm;

(C) define levels of review;

(D) identify factors that led to the event;

(E) identify opportunities for improvement;

(F) establish action plans to address the opportunities for improvement;

(G) monitor the action plan until the desired change is met and sustained;

(H) establish a concurrent PIPS process;

(I) meet staffing standards that align with the ACS standards for performance improvement personnel; and

(J) utilize terminology for classifying morbidity and mortality with the terms:

(i) morbidity or mortality without opportunity;

(ii) morbidity or mortality with opportunity for improvement; and

(iii) morbidity or mortality with regional opportunity for improvement.

(24) The trauma PIPS plan must be approved by the TMD, TPM, and the trauma operations committee and be disseminated to all departments providing care to the trauma patient. The departments must ensure staff are knowledgeable of the responsibilities in the trauma PIPS plan and the requested data and information to be presented at the trauma operations committee.

(25) The Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must demonstrate that the TMD chairs the secondary level of performance review, chairs the trauma multidisciplinary peer review committee, and co-chairs the trauma operations committee with the TPM.

(26) The trauma PIPS plan must outline the roles and responsibilities of the trauma operations committee and its membership.

(27) The trauma facility must document and include in its trauma PIPS plan the external review of the trauma verification and designation assessment questionnaire, designation survey documents, the designation survey summary report, including the medical record reviews, and all communication with the department.

(28) Trauma facilities must submit required trauma registry data every 90 days or quarterly to the State Trauma Registry and have documented evidence of data validation and correction of identified errors or blank fields.

(A) All levels of trauma facilities must demonstrate the current ACS standards for staffing requirements for the trauma registry are met.

(B) Trauma facilities utilizing a pool of trauma registrars must have an identified trauma registrar from the pool assigned to the facility to ensure data requests are addressed in a timely manner.

(29) All levels of trauma facilities must demonstrate the registered nurses assigned to care for arriving patients meeting trauma activation guidelines have current TNCC or ATCN, ENPC or PALS, and Advanced Cardiac Life Support certifications. Those new to the facility or the facility's trauma resuscitation area must meet these requirements within 18 months.

(30) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must have evidence the trauma program surgeons, trauma liaisons, trauma program personnel, operating suite leaders, and critical care medical director and nursing leaders complete a mass casualty response training on their roles, potential job functions, and job action sheets, to ensure competency regarding actions required for surge capacity, capabilities, and patient flow management from resuscitation to inpatient admission, operative suite, and critical care units or intensive care units during a multiple casualty or mass casualty event. If the facility has responded to an actual mass casualty event during a 12-month period, the facility is exempt from this training but must have documented evidence of participation in the after-action review.

(31) Level IV facilities managing 101 or more patients meeting NTDB registry inclusion criteria annually must:

(A) meet the current ACS Level IV standards and defined state requirements;

(B) have 24-hour on-site coverage by an emergency physician credentialed by the hospital and approved by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and respond to trauma activation patients within 30 minutes of request;

(C) have documented guidelines for trauma activations, resuscitation guidelines, documentation standards, and patient transfers, and measures to monitor the guidelines through the trauma performance improvement process. Transfer reviews must include the time of arrival, transfer decision time, transfer acceptance time, transport arrival time, and time transferred;

(D) have documented management guidelines specific to the trauma patients admitted at the facility based on trauma registry data;

(E) have a written trauma PIPS plan that, at minimum, monitors:

(i) trauma team activations;

(ii) trauma team member response times;

(iii) trauma resuscitation guidelines;

(iv) documentation standards;

(v) trauma management guidelines;

(vi) pediatric trauma resuscitation guidelines;

(vii) transfer guidelines; and

(viii) all trauma deaths; and

(F) have provisions for a multidisciplinary trauma peer review committee and a trauma operations committee.

(32) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually must:

(A) have 24-hour emergency services coverage by a physician credentialed by the hospital and approved by the TMD to participate in the resuscitation and treatment of trauma patients of all ages and respond to trauma activation patients within 30 minutes of request;

(B) have a TMD overseeing and monitoring the trauma care provided and who is current in ATLS;

(C) have a TPM who is a registered nurse and must:

(i) complete a trauma performance improvement course and a trauma program manager course approved by the department;

(ii) complete a registry AAAM Injury Scoring Course;

(iii) have current TNCC or ATCN, ENPC or PALS, and ACLS certifications; and

(iv) oversee and monitor trauma care provided;

(D) have documented guidelines for trauma team activation with response times, resuscitation guidelines, and documentation standards for resuscitation through admission, transfer, or discharge;

(E) have documented management guidelines specific for the trauma patients admitted to the facility;

(F) have documented transfer guidelines that are monitored to identify the arrival time, decision to transfer time, time of transfer acceptance, time of transport arrival, and time of transfer;

(G) have a trauma PIPS plan that, at minimum, monitors:

(i) trauma team activations;

(ii) trauma team member response times;

(iii) trauma resuscitation guidelines;

(iv) documentation standards;

(v) trauma management guidelines;

(vi) pediatric trauma resuscitation guidelines;

(vii) transfer guidelines; and

(viii) all trauma deaths;

(H) have provisions for a trauma multidisciplinary peer review process and operational oversight integrated into the hospitals performance review or quality review processes;

(I) have provisions for a trauma registry and submit the NTDB data to the State Trauma Registry quarterly to include each patient's ISS;

(J) have conventional radiology available 24-hours per day;

(K) have laboratory services available 24-hours per day for standard analysis of blood, urine, and other body fluids, including microbiologic sampling when appropriate;

(L) have blood bank capabilities including typing and cross-matching and have a minimum of two universal packed red blood cell units available; and

(M) participate in the local RAC.

(i) A facility seeking trauma designation or renewal of designation must submit the completed designation application packet, have the required documents available at the time of the designation survey, and submit the designation survey summary report and medical record reviews following the completed designation survey.

(1) A complete application packet contains the following:

(A) a trauma designation application for the requested level of trauma designation;

(B) a completed department designation assessment questionnaire;

(C) the documented trauma designation survey summary report that includes findings of requirements met and medical record reviews;

(D) evidence of documented data validation and quarterly submission to the State Trauma Registry and NTDB (if applicable) for the past 12 months;

(E) evidence of the facility's trauma program participation at RAC meetings throughout the designation cycle;

(F) full payment of the non-refundable, non-transferrable designation fee and department remit form submitted to the department Cash Branch per the designation application instructions; and

(G) the documentation in subparagraphs (A), (B), (D), and (E) of this paragraph must be submitted to the department and department-approved survey organization no less than 45 days before the facility's scheduled designation survey.

(2) The facility must have the required documents available and organized for the actual designation survey, including:

(A) documentation of a minimum of 12 months of trauma performance improvement and patient safety reviews, including minutes and attendance of the trauma operations meetings and the trauma multidisciplinary peer review committee meetings, all trauma-documented management guidelines or evidence-based practice guidelines, and all trauma-related policies, procedures, and diversion times;

(B) evidence of 12 months of trauma registry submissions to the State Trauma Registry;

(C) documentation of all injury prevention, outreach education, public education, and research activities (if applicable); and

(D) documentation to reflect designation requirements are met.

(3) Not later than 90 days after the trauma designation survey, the facility must submit to the department the following documentation:

(A) the documented trauma designation survey summary report that includes the requirements met and not met, and the medical record reviews; and

(B) a POC, if required by the department, which addresses all designation requirements defined as "not met" in the trauma designation survey summary report, which must include:

(i) a statement of the cited designation requirement not met;

(ii) a statement describing the corrective actions taken by the facility seeking trauma designation to meet the requirement;

(iii) the title of the individuals responsible for ensuring the corrective actions are implemented and monitored;

(iv) the date the corrective actions are implemented;

(v) a statement on how the corrective actions will be monitored and what data are measured to identify change;

(vi) documented evidence the POC is implemented within 60 days of the survey date; and

(vii) any subsequent documents requested by the department.

(4) The application includes full payment of the appropriate non-refundable, non-transferrable designation fee.

(A) For Level I and Level II trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $5,000 and a lower limit of $4,000.

(B) For Level III trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $2,500 and a lower limit of $1,500.

(C) For Level IV trauma facility applicants, the fee is no more than $10 per licensed bed with an upper limit of $1000 and a lower limit of $500.

(5) All application documents except the designation fee are submitted electronically to the department.

(j) Facilities seeking initial trauma designation must complete a scheduled conference call with the department and include the facility's chief executive officer (CEO), CNO, chief operating officer (COO), trauma administrator or executive leader, TMD, and TPM before scheduling the designation survey. The following information must be provided to the department before the scheduled conference call with the department:

(1) job descriptions for the TMD, TPM, and trauma registrar;

(2) trauma operational plan;

(3) trauma PIPS plan;

(4) trauma activation and trauma management guidelines; and

(5) trauma registry procedures.

(k) Facilities seeking designation renewal must submit the required documents described in subsection (i) of this section to the department no later than 90 days before the facility's current trauma designation expiration date.

(l) The application will not be processed if a facility seeking trauma designation fails to submit the required application documents and designation fee.

(m) A facility requesting designation at a different level of care or experiencing a change in ownership or a change in physical address must notify the department and submit a complete designation application packet and application fee.

(n) Level I, II, and III facilities, and Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must schedule a designation survey with a department-approved survey organization. All aspects of the designation survey process must follow the department designation survey guidelines. All initial designation surveys must be performed in person unless approval for virtual review is given by the department.

(1) Facilities requesting Level I and II trauma facility designation must request a verification survey through the ACS trauma verification program. This includes pediatric stand-alone facilities.

(2) Level III facilities must request a designation survey through either the ACS trauma verification program or through a department-approved survey organization.

(3) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually must schedule a designation survey with a department-approved survey organization.

(4) Level IV facilities managing 100 or less trauma patients meeting the NTDB registry inclusion criteria annually must schedule a designation survey with the department or the facility's executive officers may request a designation survey with a department-approved survey organization.

(5) The facility must notify the department of the date of the scheduled designation survey a minimum of 60 days before the survey.

(6) The facility is responsible for any expenses associated with the designation survey.

(7) The department, at its discretion, may appoint a designation coordinator to participate in the survey process. The designation coordinator's costs are borne by the department.

(o) The survey team composition must be as follows:

(1) Level I or Level II facilities must be reviewed by a team of surveyors who do not practice in Texas and who currently participate in the management or oversight of trauma patients at a verified or designated Level I or II trauma facility. The survey team must include:

(A) two surgeons;

(B) an emergency medicine physician; and

(C) a registered nurse with trauma expertise.

(2) Level III facilities must be reviewed by a team of surveyors currently participating in the management or oversight of trauma patients at a verified or designated Level I, II, or III trauma facility. The survey team must include:

(A) a surgeon; and

(B) a registered nurse with trauma expertise.

(3) Level IV facilities must be reviewed by surveyors determined by the facility's number of trauma patients meeting NTDB registry inclusion criteria annually that are managed by the facility.

(A) Level IV facilities managing 101 or more trauma patients meeting NTDB registry inclusion criteria annually with:

(i) evidence of trauma patients having operative interventions, being admitted to the ICU, or having an ISS of 15 or greater must be reviewed by:

(I) a surgeon; and

(II) a registered nurse with trauma expertise;

(ii) no evidence of operative interventions, but trauma patients are admitted to the ICU and have an ISS of 15 or greater must be reviewed by:

(I) a surgeon, emergency medicine physician, or family practice physician who has the role of TMD or trauma liaison at their facility; and

(II) a registered nurse with trauma expertise;

(iii) no evidence of operative interventions or ICU admissions must be reviewed by:

(I) a surgeon, emergency medicine physician, family practice physician; or

(II) a registered nurse with trauma expertise.

(B) Level IV facilities managing 100 or less trauma patients meeting NTDB registry inclusion criteria annually have the option of requesting a designation survey by:

(i) the department; or

(ii) a department-approved survey organization. If this option is chosen, the survey team must include:

(I) a surgeon, an emergency medicine physician, or family practice physician, currently serving in the role of TMD or trauma liaison; or

(II) a registered nurse with trauma expertise.

(p) Trauma facilities seeking designation or redesignation and department-approved survey organizations must follow the department survey guidelines and ensure all surveyors follow these guidelines.

(1) All members of the survey team for Level III or IV, except department staff, must not be from the same TSA or a contiguous TSA of the facility's location without the written approval from the department. There must be no business or patient care relationship or any known conflict of interest between the surveyor or the surveyor's place of employment and the facility being surveyed.

(2) The facility must not accept surveyors with any known conflict of interest. If a conflict of interest is present, the facility seeking trauma designation must decline the assigned surveyor through the survey organization.

(A) A conflict of interest exists when the surveyor has a direct or indirect financial, personal, or other interest which would limit or could reasonably be perceived as limiting the surveyor's ability to serve in the best interest of the public.

(B) The conflict of interest may include a surveyor who, in the past four years:

(i) has trained or supervised key hospital or medical staff in residency or fellowship;

(ii) collaborated professionally with key members of the facility's leadership team;

(iii) was employed in the same health care system in state or out of state;

(iv) participated in a designation consultation with the facility;

(v) had a previous working relationship with the facility or facility leader;

(vi) conducted a designation survey for the facility; or

(vii) is the EMS medical director for an agency that routinely transports trauma patients to the facility.

(3) If a designation survey occurs with a surveyor who has a known conflict of interest, the trauma designation survey summary report and medical record review may not be accepted by the department.

(4) A survey organization must complete an application requesting to perform designation surveys in Texas and be approved by the department. Each organization must renew its application every four years.

(q) Level I and II facilities using the ACS verification program who receive a Type I or three or more Type II standards not met, and Level III facilities surveyed by a department-approved survey organization with four or more requirements not met, must schedule a conference call with the department.

(r) If a health care facility seeking re-designation fails to meet the requirements outlined in subsection (j) of this section, the original designation expires on its expiration date. The facility must wait six months and begin the process again to continue as a designated trauma facility.

(s) If a facility disagrees with the designation level awarded by the department, the CEO, CNO, or COO may request an appeal, in writing, sent to the EMS/Trauma Systems Section director not later than 30 days after the issuance date of a designation award.

(1) All written appeals are reviewed quarterly by the EMS/Trauma Systems Section director in conjunction with the Trauma Designation Review Committee.

(A) The Trauma Designation Review Committee consists of the following individuals for trauma designation appeals, exception requests, or contingent designation survey summaries:

(i) chair of Governor's EMS and Trauma Advisory Council (GETAC);

(ii) chair of the GETAC Trauma System Committee;

(iii) current president of the Texas Trauma Coordinators Forum;

(iv) two individuals who each have a minimum of 10 years of trauma facility oversight as an administrator, medical director, program manager, or program liaison, all selected by the current chair of GETAC and approved by the EMS/Trauma Systems Section director and Consumer Protection Division (CPD) associate commissioner; and

(v) three department representatives from the EMS/Trauma Systems Section.

(B) The Trauma Designation Review Committee meetings are closed to maintain confidentiality for all reviews.

(C) The GETAC chair and the chair of the Trauma System Committee are required to attend the Trauma Designation Review Committee, in addition to a minimum of three of the other members, to conduct meetings with the purpose of reviewing trauma facility designation appeals, exception requests, and contingent designation survey summaries that identify requirements not met. Agreement from a majority of the members present is required.

(2) If the Trauma Designation Review Committee supports the department's designation determination, the EMS/Trauma Systems Section director gives written notice of the review and determination

to the facility not later than 30 days after the committee's recommendation.

(3) If the Trauma Designation Review Committee recommends a different level of designation, it will provide the recommendation to the department. The department reviews the recommendation and determines the approved level of designation. Additional actions, such as a focused review, re-survey, or submission of information and reports to maintain designation, may be required by the department for identified designation requirements not met or only partially met.

(4) If a facility disagrees with the department's awarded level of designation, the facility may request a second appeal review with the department's CPD associate commissioner. The appeal must be submitted to the EMS/Trauma Systems Section no later than 15 days after the issuance date of the department's designation. If the CPD associate commissioner disagrees with the Trauma Designation Review Committee's recommendation, the CPD associate commissioner decides the appropriate level of designation awarded. The department sends a notification letter of the second appeal decision within 30 days of receiving the second appeal request.

(5) If the facility continues to disagree with the second level of appeal, the facility may request a hearing, governed by the department's rules for a contested case hearing and by Texas Administrative Procedure Act, Texas Government Code Chapter 2001, and the department's formal hearing procedures in §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures).

(t) All designated facilities must follow the exceptions and notifications process outlined in the following paragraphs.

(1) A designated trauma facility must provide written or electronic notification of any significant change to the trauma program impacting the capacity or capabilities to manage and care for a trauma patient. The notification must be provided to:

(A) all EMS providers that transfer trauma patients to or from the designated trauma facility;

(B) the hospitals to which it customarily transfers out or from which it transfers in trauma patients;

(C) applicable RACs; and

(D) the department.

(2) If the designated trauma facility is unable to meet the requirements to maintain its current designation, it must submit to the department a documented POC and a request for a temporary exception to the designation requirements. Any request for an exception must be submitted in writing from the facility's CEO and define the facility's timeline to meet the designation requirements. The department reviews the request and the POC and either grants the exception with a timeline based on access to care, including geographic location, other levels of trauma facilities available, transport times, impact on trauma outcomes, and the regional trauma system, or denies the exception. If the facility is not granted an exception or it does not meet the designation requirements at the end of the exception period, the department elects one of the following:

(A) review the exception request with the Trauma Designation Review Committee with consideration of geographic location, access to trauma care in the local area of the facility, and impact on the regional trauma system;

(B) re-designate the facility at the level appropriate to its revised capabilities;

(C) outline an agreement with the facility to satisfy all designation requirements for the level of care designation within a time specified under the agreement, which may not exceed the first anniversary of the effective date of the agreement; or

(D) accept the facility's relinquishing of its trauma designation certificate.

(3) If the facility is relinquishing its trauma designation, the facility must provide 30 day written advance notice of the relinquishment to the department. The facility informs the applicable RACs, EMS providers, and facilities to which it customarily transfers out or from which it transfers in trauma patients. The facility is responsible for continuing to provide trauma care services or ensuring a plan for trauma care continuity for 30 days following the written notice of relinquishment of its trauma designation.

(u) A designated trauma facility may choose to apply for a higher level of designation at any time. The facility must follow the initial designation process described in subsection (i) of this section to apply for a higher level of trauma designation. The facility must not claim or advertise the higher level of designation until the facility has received written notification of the award of the higher level of designation.

(v) A hospital providing trauma services must not use or authorize the use of any public communication or advertising containing false, misleading, or deceptive claims regarding its trauma designation status. Public communication or advertising is deemed false, misleading, or deceptive if the facility uses these, or similar, terms:

(1) trauma facility, trauma hospital, trauma center, functioning as a trauma center, serving as a trauma center, or similar terminology if the facility is not currently designated as a trauma center or designated trauma center at that level; or

(2) comprehensive Level I trauma center, major Level II trauma center, advanced Level III trauma center, basic Level IV trauma center, or similar terminology in its signs, website, advertisements, social media, or in the printed materials and information it provides to the public that are different than the current designation level awarded by the department.

(w) During a virtual, on-site, or focused designation review conducted by the department or a department-approved survey organization, the department or surveyor has the right to review and evaluate the following documentation to validate designation requirements are met in this section and the Texas Health and Safety Code Chapter 773:

(1) trauma patient medical records;

(2) trauma PIPS plan and process documents;

(3) appropriate committee documentation for attendance, meeting minutes, and documents demonstrating why the case was referred, the date reviewed, pertinent discussion, and any actions taken specific to improving trauma care and outcomes; and

(4) documents relevant to trauma care in a designated trauma facility or facility seeking trauma facility designation to validate evidence designation requirements are met.

(x) The department and department-approved survey organizations must comply with all relevant laws related to the confidentiality of such records.

§157.130. Funds for Emergency Medical Services, Trauma Facilities, and Trauma Care Systems, and the Designated Trauma Facility and Emergency Medical Services Account.

(a) Allocations determination under Texas Health and Safety Code §773.122 and Health and Safety Code Chapter 780.

(1) Department determination. The department determines each year:

(A) eligibility criteria for emergency medical services (EMS), trauma service area (TSA), and hospital allocations; and

(B) the amount of EMS, TSA, and hospital allocations based on language described in Texas Health and Safety Code §773.122 and Chapter 780.

(2) Eligibility requirements. To be eligible for funding from the accounts, all potential recipients must maintain the regional participation requirements.

(3) Extraordinary emergency funding.

(A) To be eligible to receive extraordinary emergency funding, an entity must meet the following requirements:

(i) be a licensed EMS provider, a designated trauma facility, or a recognized first responder organization (FRO);

(ii) submit a completed application and any additional documentation requested by the department; and

(iii) provide documentation of active participation in its local Regional Advisory Council (RAC).

(B) Incomplete applications will not be considered for extraordinary emergency funding.

(4) EMS allocation.

(A) The department contracts with each eligible RAC to distribute the county funds to eligible EMS providers based within counties aligned with the relevant TSA.

(i) The department evaluates submitted support documents per the contract statement of work. Awarded funds must be used in addition to current operational EMS funding of eligible recipients and must not supplant the operational budget.

(ii) Funds are allocated by county to be awarded to eligible providers in each county. Funds are non-transferable to other counties within the RAC if there are no eligible providers in a county.

(B) Eligible EMS providers may contribute funds for a specified purpose within the TSA when:

(i) all EMS providers received communication regarding the intent of the contributed funds;

(ii) the EMS providers voted and approved by majority vote to contribute funds; and

(iii) all EMS providers that did not support contributing funds, receive the eligible funding.

(C) To be eligible for funding from the EMS allocation, providers must:

(i) maintain and comply with all licensure requirements as described in §157.11 of this chapter (relating to Requirements for an EMS Provider License);

(ii) follow RAC regional guidelines regarding patient destination and transport in all TSAs where EMS is provided and verified by each RAC;

(iii) notify the RACs of any potential eligibility to receive funds and meet the RACs' participation requirements, if a provider is contracted to provide EMS within a county of any one TSA and whose county of licensure is another county not in or contiguous with that TSA; and

(iv) provide the department evidence of a contract or letter of agreement with each additional county government or taxing authority in which EMS is provided in any county beyond its county of licensure.

(D) Contracts or letters of agreement must be submitted to the department on or before the stated department contract deadline of the respective year and provide evidence of continued coverage throughout the effective contract dates for which the eligibility of the EMS provider is being considered.

(E) EMS providers with contracts or letters of agreement on file with the department meeting the effective contract dates do not need to resubmit a copy of the contract or letter of agreement unless it has expired or will expire before the effective date of the next contract.

(F) The submitted contracts or letters of agreement must include effective dates to determine continued eligibility.

(G) Inter-facility transfer letters of agreement and contracts or mutual aid letters of agreement and contracts do not meet the requirement of a county contract.

(H) EMS providers are responsible for ensuring all contracts or letters of agreement have been received by the department on or before the listed deadline to be considered for eligibility.

(I) Air ambulance providers must meet the same requirements as ground transport EMS providers to be eligible to receive funds from a specific county other than the county of licensure.

(J) If an EMS provider is licensed in a particular county for a service area considered a geo-political subdivision and whose boundary lines cross multiple county lines, it will be considered eligible for the EMS Allocation for all counties overlapped by that geo-political subdivision's boundary lines. Verification from local jurisdictions will be requested for every county that comprises the geo-political subdivision to determine funding eligibility for each county. The eligibility of EMS providers whose county of licensure is in a geo-political subdivision other than those listed in clauses (i) - (v) of this subparagraph will be evaluated on a case-by-case basis. Geo-political subdivisions include:

(i) municipalities;

(ii) school districts;

(iii) emergency service districts (ESDs);

(iv) utility districts; or

(v) prison districts.

(5) TSA allocation.

(A) The department contracts with eligible RACs to distribute the funds for the operation of the 22 TSAs and for equipment, communications, education, and training for the areas.

(B) To be eligible to distribute funding on behalf of eligible recipients in each county to the TSA, a RAC must be:

(i) officially recognized by the department as described in §157.123 of this subchapter (relating to Regional Advisory Councils);

(ii) in compliance with all RAC performance criteria, have a current RAC self-assessment, and have a current regional trauma and emergency health care system plan; and

(iii) incorporated as an entity exempt from federal income tax under Section 501(a), Internal Revenue Code of 1986, and

its subsequent amendments by being listed as an exempt organization under Section 501(c)(3).

(C) The TSA allocation distributed under this paragraph is based on the relative geographic size and population of each TSA and on the relative amount of trauma care provided.

(6) Hospital allocation. The department distributes funds to designated trauma facilities to subsidize a portion of uncompensated trauma care provided or to enhance the facility's delivery of trauma care.

(A) Funds distributed from the hospital allocations are made based on:

(i) the hospital being designated as a trauma facility by the department as defined in Texas Health and Safety Code Chapter 773;

(ii) the percentage of the hospital's uncompensated trauma care cost for patients meeting the National Trauma Data Bank (NTDB) registry inclusion criteria relative to the total uncompensated trauma care cost reported for the identified patient population by qualified facilities that year;

(iii) availability of funds; and

(iv) submission of a complete application to the department within the stated time frame. Incomplete applications will not be considered.

(B) Additional information may be requested by the department to determine eligibility for funding.

(C) A designated trauma facility in receipt of funding from the hospital allocation that fails to maintain its designation as required in §157.125 of this subchapter (relating to Requirements for Trauma Facility Designation Effective Through August 31, 2025) and §157.126 of this subchapter (relating to Trauma Facility Designation Requirements Effective on September 1, 2025), must return to the department all hospital allocation funds received in the prior 12 months within 90 days of failure to maintain trauma designation.

(D) The department may grant an exception to subparagraph (C) of this paragraph if it finds compliance with this section would not be in the best interest of the persons served in the affected local system.

(E) A facility must have no outstanding balance owed to the department or other state agencies before receiving any future disbursements from the hospital allocation.

(7) Department allocations. The department's process for funding allocations defined in this subsection applies to the account defined in Texas Health and Safety Code Chapter 780 and includes designated trauma facilities and those in active pursuit of trauma designation in the funding allocation.

(8) Department unawarded designation. An undesignated facility in active pursuit of designation but that has not been awarded a trauma designation by the department pursuant to Texas Health and Safety Code §780.004 must return to the department all funds received from the hospital allocation, plus a penalty of 10 percent of the awarded amount.

(b) Calculation methods. Calculation of county portions of the EMS allocation, the RAC portions of the TSA allocation, and the hospital allocation are:

(1) EMS allocation.

(A) EMS allocation is derived by adjusting the weight of the statutory criteria to ensure, as closely as possible:

(i) 40 percent of the funds go to urban counties; and

(ii) 60 percent of the funds go to rural counties.

(B) An individual county's portion of the EMS allocation is based on its geographic size, population, and the number of emergency health care runs, multiplied by adjustment factors determined by the department, so the distribution approximates the required percentages for urban and rural counties.

(C) The formula is:

(i) the county's population multiplied by an adjustment factor;

(ii) plus, the county's geographic size multiplied by an adjustment factor;

(iii) plus, the county's total emergency health care runs multiplied by an adjustment factor;

(iv) divided by 3; and

(v) multiplied by the total EMS allocation.

(D) The adjustment factors are manipulated so the distribution approximates the required percentages for urban and rural counties.

(E) Total emergency health care runs are the number of emergency patient care records electronically transmitted to the department in a given calendar year by EMS providers.

(2) TSA allocation.

(A) The TSA allocation is based on its relative geographic size, population, and trauma care provided as compared to all other TSAs.

(B) The formula is:

(i) the TSA's percentage of the state's total population;

(ii) plus, the TSA's percentage of the state's total geographic size;

(iii) plus, the TSA's percentage of the state's total trauma care;

(iv) divided by 3; and

(v) multiplied by the total TSA allocation.

(C) Total trauma care is the number of trauma patient records electronically transmitted to the department in a given calendar year by EMS providers and hospitals.

(3) Hospital allocation.

(A) Distributions, including unexpended portions of the EMS and TSA allocations, are determined by an annual application process.

(B) An annual application must be submitted each state fiscal year. Incomplete applications will not be considered for the hospital allocation calculation.

(C) Based on the information provided in the approved application, each facility will receive allocations as follows.

(i) An equal amount, not to exceed 20 percent of the available hospital allocation, to reimburse designated trauma facilities and those facilities in active pursuit of designation under the program.

(ii) Any funds not allocated in paragraphs (1) and (2) of this subsection are included in the distribution formula in subparagraph (E) of this paragraph.

(D) If the total cost of uncompensated trauma care for patients meeting NTDB registry inclusion criteria exceeds the amount appropriated from the account, minus the amount referred to in subparagraph (C)(i) of this paragraph, the department allocates funds based on a facility's percentage of uncompensated trauma care costs in relation to the total uncompensated trauma care cost reported by qualified hospitals for the funding year.

(E) The hospital allocation formula for trauma designated facilities is:

(i) the facility's reported costs of uncompensated trauma care;

(ii) minus any collections received by the facility for any portion of the facility's uncompensated trauma care previously reported for the purposes of this section;

(iii) divided by the total reported costs of uncompensated trauma care by eligible facilities; and

(iv) multiplied by the total money available after reducing the amount to be distributed in subparagraph (C)(i) of this paragraph.

(F) The reporting period of a facility's uncompensated trauma care must apply to costs incurred during the preceding calendar year.

(c) Loss of funding eligibility. If the department finds an EMS provider, RAC, or hospital has violated Texas Health and Safety Code Chapter 773 or fails to comply with this chapter, the department may withhold account monies for a period of one to three years, depending upon the seriousness of the infraction.

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

Filed with the Office of the Secretary of State on November 4, 2024.

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Cynthia Hernandez
General Counsel
Department of State Health Services
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Proposal publication date: August 2, 2024
For further information, please call: (512) 535-8538

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 506. SPECIAL CARE FACILITIES

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §506.61, concerning Inspection and Investigation Procedures, and §506.62, concerning Complaint Against a Texas Department of Health Representative; new §506.61, concerning Integrity of Inspections and Investigations; §506.62, concerning Inspections; §506.63, concerning Complaint Investigations; §506.64, concerning Notice; §506.65, concerning Professional Conduct; and §506.66, concerning Complaint Against an HHSC Representative; and amended §506.71, concerning License Denial, Suspension, Revocation and Probation, and §506.73, concerning Administrative Penalties.

The repeal of §506.61 and §506.62; new §§506.64, 506.65, and 506.66; and amended §506.73 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3122). These rules will not be republished.

New §§506.61, 506.62, and 506.63, and amended §506.71 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3122). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to update the inspection, complaint investigation, and enforcement procedures for special care facilities. These updates are necessary to hold facilities accountable during the inspection and investigation processes and ensure facilities provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for special care facilities from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from four commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Council for Developmental Disabilities (TCDD), and the Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: TCDD recommended HHSC revise §506.63 to add language to require HHSC to notify the reporter in writing within a specific timeframe, and provided as an example, within 48 hours after HHSC makes a decision regarding the investigation.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation.

Comment: CCHR recommended HHSC revise §506.63(a) to include a prompt to call 911 in cases for abuse and adding the contact information for the federally mandated protection and advocacy system to the posting required by that subsection to eliminate the need for multiple postings.

Response: HHSC declines to revise §506.63(a) because this subsection is specific to reporting allegations to HHSC. HHSC notes this subsection does not preclude a facility from combining the signage with other required postings.

Comment: Regarding §506.63(c)(1), DRTx stated there is not an indication of a feedback loop to the original reporter if HHSC does not investigate an allegation, refers an investigation to another entity, or does not pursue any action with the investigation. DRTx requested HHSC add language to §506.63(c)(1) requiring HHSC to notify the reporter in writing, within a specific timeframe,

and suggested 48 hours after HHSC makes a decision regarding an investigation's outcome.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake process.

Comment: TCDD expressed concern with the use of "may" instead of "shall" in §506.63(c)(1) and (2). TCDD recommended HHSC revise §506.63(c)(1) and (2) by adding language requiring HHSC to provide feedback, within a specified timeframe, to a reporter about whether and why HHSC decided to investigate and, when applicable, to whom HHSC referred the allegation.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake processes.

Comment: CCHR requested HHSC inform a complainant of HHSC's decision not to investigate an allegation, and when applicable, to whom HHSC referred the allegation under §506.63(c)(1) and (2). CCHR also requested HHSC add information to this subsection regarding any right for a complainant to appeal and the procedures and timelines for filing an appeal.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §510.63 further because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator. HHSC notes the HHSC Complaint and Incident Intake webpage contains information about the complaint intake processes.

Comment: CCHR commented on §506.63(d) and (e) and stated these subsections would be problematic if a regulatory approach was taken in lieu of conducting an actual abuse, neglect, or exploitation investigation because abuse, neglect, and exploitation are potential criminal matters that require patient protection and prompt collection and preservation of evidence.

Response: HHSC notes that it investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2); and reports possible criminal acts to the appropriate law enforcement authorities in accordance with state law and HHSC policies.

Comment: TCDD recommended HHSC revise §506.63(e) to clearly state that unannounced, on-site investigations also apply to investigations of abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.63(e) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2). HHSC notes the language at §506.63(e) does not preclude HHSC from conducting an unannounced, on-site investigation regarding other allegations of abuse, neglect, or exploitation in accordance with HHSC policies.

Comment: DRTx stated §506.63(e) seems to address regulatory investigations and recommended adding language to the subsection regarding HHSC's ability to conduct an unannounced, on-site investigation regarding an allegation of abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.63(e) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2). HHSC notes the language at §506.63(e) does not preclude HHSC from conducting an unannounced, on-site investigation regarding other allegations of abuse, neglect, or exploitation in accordance with HHSC policies.

Comment: TCDD recommended HHSC revise §506.64(b)(2) to include procedures for how HHSC should conduct a regulatory investigation and that the procedures followed for abuse, neglect, and exploitation investigations should be similarly addressed and clearly identified as abuse, neglect, and exploitation procedures.

Response: HHSC declines to revise §506.64(b)(2) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with 25 TAC Chapter 1, Subchapter Q; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: DRTx noted the language in §506.64(b)(2) focuses on regulatory issues and stated it is not clear if allegations of abuse, neglect, or exploitation investigated under this section result in a determination, identification of an alleged perpetrator associated with the allegation, or if HHSC takes any disciplinary action against a confirmed perpetrator. DRTx recommended adding language in §506.64(b)(2) to include the process for abuse, neglect, and exploitation allegations.

Response: HHSC declines to revise §506.64(b)(2) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q, and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: TMA stated §506.65 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §506.65 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §506.65 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: TCDD recommended HHSC revise §506.71(b)(3) to include language referencing the standards for investigation and corrective action for confirmed abuse, neglect, or exploitation.

Response: HHSC declines to revise §506.71(b)(3) because HHSC investigates allegations of abuse, neglect, or exploitation involving individuals with disabilities, children, or elderly individuals in accordance with the investigation rules at 25 TAC Chapter 1, Subchapter Q and HHSC policies; and HHSC investigates other abuse, neglect, and exploitation allegations in accordance with 25 TAC §506.33(c)(2).

Comment: CCHR stated a 30-day minimum probation period under §506.71(i) is too short and questioned whether this probation period would provide a sufficient deterrent to prevent behavior severe enough to warrant a license denial, suspension, or revocation.

Response: HHSC declines to revise §506.71(i) because the language is consistent with Texas Health and Safety Code §248.051(c). In addition, HSC §248.051(d) provides for HHSC to suspend or revoke the license of a special care facility that does not correct items that were in noncompliance or that does not comply with the applicable requirements within the applicable probation period.

Comment: TCDD recommended HHSC add language to §506.73(e) to require HHSC to inform the reporter, alleged victim, and the alleged victim's legally authorized representative (LAR) of the allegation's disposition and appeal procedures within a specified timeline. CCHR commented on §506.73(e) and stated that the alleged perpetrator has a right to receive notice of a violation and any proposed penalty and questioned whether the victims of such conduct that led to an administrative penalty should also be notified of violations and penalties.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §506.73(e) to add an appeals process because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator.

Comment: Regarding §506.73(e)(1) and (2), DRTx stated that the reporter, alleged victim, and alleged victim's LAR have a right to know the outcome of an investigation and be informed of how to access the report and of any appeal process. DRTx also noted the current language fails to indicate if any appeal process exists. DRTx recommended HHSC add language to §506.73(e)(1) and (2) to require HHSC to share the outcome of the investigation with the reporter, alleged victim, and the alleged victim's LAR, if appropriate, within a specific timeframe. DRTx also recommended HHSC provide information in §506.73(e)(1) and (2) on the appeal process.

Response: HHSC revises §506.63 to add language at new subsection (n) stating HHSC notifies a complainant of the investigation's outcome within 10 business days of completing the investigation. HHSC declines to revise §506.73(e)(1) because investigations under §506.63 do not provide an appeal process for a complainant or an alleged violator.

HHSC revised §506.61(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81(a) and the limited services rural hospital rule at 26 TAC §511.111(a).

HHSC revised §506.61(a)(2) by adding "unless the facility first informs HHSC" to clarify a facility must first inform HHSC and then obtain HHSC written approval before beginning to record or listen to an internal HHSC discussion.

HHSC revised §506.62(d) and §506.63(g) by adding "video surveillance" to the list of items a special care facility must permit HHSC to examine during any HHSC inspection. The revisions increase consistency with other HHSC rules in this rule project and language in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC made editorial changes to §506.71(c) to renumber paragraph (2)(H) as paragraph (3), because the contents are a separate rule that references paragraph (2) of this subsection.

SUBCHAPTER E. INSPECTIONS AND INVESTIGATIONS

26 TAC §506.61, §506.62

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

26 TAC §§506.61 - 506.66

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

§506.61. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a facility:

(1) may not record, listen to, or eavesdrop on any HHSC interview with facility staff or residents that the facility staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless the facility first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A facility shall inform HHSC when security cameras or other existing recording devices in the facility are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits facility staff to be present, an interview or conversation for which facility staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§506.62. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an unannounced, on-site inspection of a facility at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a facility's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(b) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its facilities by HHSC.

(c) HHSC inspections to evaluate a facility's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed facility is offering or providing, or purporting to offer or provide treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(d) A facility shall cooperate with any HHSC inspection and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the facility, unless prohibited by law.

(e) A facility shall permit HHSC access to interview members of the governing body, personnel, and residents, including the opportunity to request a written statement.

(f) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(g) HHSC shall maintain the confidentiality of facility records as applicable under state and federal law.

(h) Upon entry, HHSC holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the facility representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the inspection, including possible health and safety concerns. The facility may provide any final documentation regarding compliance during the exit conference.

§506.63. Complaint Investigations.

(a) A facility shall provide each resident and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the facility.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The facility shall prominently and conspicuously post this statement in resident common areas and in visitor's areas and waiting rooms so that it is readily visible to residents, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to residents, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC shall conduct investigations to evaluate a facility's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of residents.

(e) HHSC may conduct an unannounced, on-site investigation of a facility at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a facility's compliance with any applicable statute or rule;

(2) a facility's plan of correction;

(3) a facility's compliance with an order of the executive commissioner or the executive commissioner's designee;

(4) a facility's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A facility shall cooperate with any HHSC investigation and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the facility, unless prohibited by law.

(h) A facility shall permit HHSC access to interview members of the governing body, personnel, and residents, including the opportunity to request a written statement.

(i) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) HHSC shall maintain the confidentiality of facility records as applicable under state and federal law.

(k) Upon entry, the HHSC representative holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the investigation.

(l) The HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the investigation. The facility may provide any final documentation regarding compliance during the exit conference.

(m) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(n) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

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

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SUBCHAPTER F. ENFORCEMENT

26 TAC §506.71, §506.73

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation of and provision services by the health and human services agencies, and Texas Health and Safety Code §248.026, which requires HHSC to adopt rules that establish minimum standards for special care facilities.

§506.71. License Denial, Suspension, Revocation and Probation.

(a) Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(b) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of Health and Safety Code (HSC) Chapter 248 (relating to Special Care Facilities) and this chapter. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for:

(1) failure to comply with any applicable provision of the HSC, including Chapter 248;

(2) failure to comply with any provision of this chapter or any other applicable laws;

(3) the facility, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a resident;

(4) the facility, or any of its employees, materially altering any license issued by HHSC;

(5) failure to comply with minimum standards for licensure;

(6) failure to provide a complete license application;

(7) failure to comply with an order of the HHSC executive commissioner or another enforcement procedure under HSC Chapter 248;

(8) a history of failure to comply with the applicable rules relating to resident environment, health, safety, and rights;

(9) the facility aiding, committing, abetting, or permitting the commission of an illegal act;

(10) the facility, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the facility pursuant to HSC Chapter 248 and the provisions of this chapter;

(11) failure to timely pay an assessed administrative penalty as required by HHSC;

(12) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(13) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction; or

(14) failure to comply with applicable requirements within a designated probation period.

(c) HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a facility.

(1) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53.

(2) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a facility:

(A) a misdemeanor violation of HSC Chapter 248;

(B) a misdemeanor or felony involving moral turpitude;

(C) a misdemeanor or felony relating to deceptive business practice;

(D) a misdemeanor or felony of practicing any health-related profession without a required license;

(E) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(F) a misdemeanor or felony under Texas Penal Code (TPC) Title 5, involving a patient, resident, or client of any health care facility, a home and community support services agency, or a health care professional;

(G) a misdemeanor or felony under TPC:

(i) Title 4;

(ii) Title 5;

(iii) Title 7;

(iv) Title 8;

(v) Title 9;

(vi) Title 10; or

(vii) Title 11.

(3) Offenses listed in paragraph (2) of this subsection are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign or military jurisdictions that indicate an inability or tendency for the person to be unable to own or operate a facility.

(d) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(e) If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC, or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(f) Within 20 calendar days after receipt of the notice, the applicant or licensee may notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(g) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days after receipt of the notice. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(1) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001 and Texas Administrative Code Title 1 Chapter 357, Subchapter I (relating to Hearings Under the Administrative Procedure Act).

(2) If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving the notice of the proposed action described in subsection (e) of this section, the applicant or licensee is deemed to have waived the opportunity for a hearing and HHSC shall take the proposed action.

(h) HHSC may issue an emergency order to suspend a license effective immediately when HHSC has reasonable cause to believe that the conduct of a license holder creates an immediate danger to public health and safety. HHSC shall notify the facility of the emergency action by mail or personal delivery of the notice. On written request of the license holder to HHSC for a hearing, HHSC refers the matter to the State Office of Administrative Hearings.

(i) In lieu of denying, suspending, or revoking the license, HHSC may place the facility on probation for a period of not less than 30 days, if HHSC finds that the facility is in repeated non-compliance with this chapter or HSC Chapter 248, and the facility's noncompliance does not endanger the public's health and safety.

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

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CHAPTER 510. PRIVATE PSYCHIATRIC HOSPITALS AND CRISIS STABILIZATION UNITS

The Texas Health and Human Services Commission (HHSC) adopts amendments to §510.1, concerning Purpose; §510.2, concerning Definitions; §510.21, concerning General; §510.22, concerning Application and Issuance of Initial License; §510.23, concerning Application and Issuance of Renewal License; §510.24, concerning Change of Ownership; §510.25, concerning Time Periods for Processing and Issuing Licenses; §510.26, concerning Fees; §510.41, concerning Facility Functions and Services; §510.42, concerning Discrimination or Retaliation Standards; §510.43, concerning Patient Transfer Policy; §510.46, concerning Abuse and Neglect Issues; §510.61, concerning Patient Transfer Agreements; §510.62, concerning Cooperative Agreements; §510.101, concerning Fire Prevention and Protection; §510.121, concerning Requirements for Buildings in which Existing Licensed Facilities are Located; §510.122, concerning New Construction Requirements; §510.123, concerning Spatial Requirements for New Construction; §510.125, concerning Building with Multiple Occupancies; §510.127, concerning Preparation, Submittal, Review and Approval of Plans; §510.128, concerning Construction, Surveys, and Approval of Project; §510.129, concerning Waiver Requests, and §510.131, concerning Tables.

Amended §§510.1, 510.2, 510.21 - 510.26, 510.41 - 510.43, 510.61, 510.62, 510.101, 510.121, 510.125 - 510.129, and 510.131 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3129). These rules will not be republished.

Amended §§510.46, 510.122, and 510.123 are adopted with changes to the proposed text as published in the May 10, 2024,

issue of the *Texas Register* (49 TexReg 3129). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to correct cross-references throughout 26 TAC Chapter 510 after the rules were administratively transferred from 25 TAC Chapter 134 to 26 TAC Chapter 510. These non-substantive amendments will maintain accurate references to 25 TAC and 26 TAC. The amendments also correct outdated citations and references to programs that no longer exist; update language to reflect current HHSC organization; and increase consistency with statute, HHSC rules, and HHSC rulemaking guidelines.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received 26 comments regarding the proposed rules from five commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), International Association of Plumbing and Mechanical Officials Group Texas (IAPMO), Texas Council for Developmental Disabilities (TCDD), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follow.

Comment: CCHR and TCDD recommended HHSC revise the crisis stabilization unit definition at §510.2(6) to allow for the admission of persons under detention and increase consistency with current 26 TAC §306.51(6).

Response: HHSC declines to revise §510.2(6) at this time because this revision is beyond the scope of this rule project.

Comment: DRTx expressed support for HHSC removing the outdated terms "learning disability" and "mental retardation," and recommended HHSC add a definition for "intellectual and developmental disability (IDD)" in §510.2 to ensure the rules apply to individuals with a dual diagnosis of mental illness and IDD.

Response: HHSC declines to add a definition in §510.2 as recommended because this revision is beyond the scope of this rule project.

Comment: DRTx and TCDD recommended HHSC retain the medical error, reportable event, and root cause analysis definitions in §510.2 that HHSC removed in the proposed amended rules.

Response: HHSC declines to reinstate the medical error, reportable event, and root cause analysis definitions in §510.2 because these terms are no longer used in 26 TAC Chapter 510. These definitions related to the patient safety program, which was created by House Bill (H.B.) 1614, 78th Legislature, Regular Session, 2003, and the requirements set forth by H.B. 1614 expired in 2007.

Comment: TCDD recommended HHSC revise §510.21(b)(1) to list all statutes and rules that apply to private psychiatric hospitals and crisis stabilization units and are enforced or enforceable.

Response: HHSC declines to revise §510.21(b)(1) at this time because this revision is beyond the scope of this rule project.

Comment: CCHR, DRTx, and TCDD recommended HHSC revise §510.41(g)(6) to include language regarding voluntary admission, discharge requests, and legal paperwork such as court orders. CCHR and TCDD also recommended HHSC add language in §510.41(g)(6) to include estimates of charges.

Response: HHSC declines to revise §510.41(g)(6) at this time because this revision is beyond the scope of this rule project.

Comment: DRTx recommended HHSC revise §510.45 to retain the phrase "in writing" to provide clarity in how the facility must provide the information to the complainant.

Response: HHSC declines to revise §510.45 at this time because this revision is beyond the scope of this rule project as §510.45 is not included in this project.

Comment: CCHR, DRTx, and TCDD recommended HHSC revise §510.46(c)(2) by adding the contact information for the state's Protection and Advocacy System to the posting requirements for complaints.

Response: HHSC declines to revise §510.46(c)(2) because this paragraph is specific to reporting allegations under Texas Health and Safety Code §161.132. HHSC notes this paragraph does not preclude a facility from combining the signage with other required postings.

Comment: DRTx recommended HHSC revise §510.46(c)(3)(A) and §510.46(c)(3)(B) to specify when to refer allegations of abuse, neglect, or exploitation to law enforcement versus HHSC for investigation.

Response: HHSC declines to revise §510.46(c)(3)(A) and §510.46(c)(3)(B) because §510.46(g)(4) contains the requirements for referring allegations to other agencies, including law enforcement. HHSC notes a facility must also comply with the abuse, neglect, and exploitation reporting requirements under HSC §161.132, Texas Family Code Chapter 261, Texas Human Resources Code Chapter 48, and Texas Civil Practice and Remedies Code §81.006.

Comment: TMA expressed its concern about the timeframe requirements in §510.46(c)(3)(A) and (B) for reporting abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because these timeframes may not always be possible or practical. TMA further stated these timeframes may discourage physicians and providers from even looking for signs of abuse, neglect, and exploitation and illegal, unprofessional, or unethical conduct because they may fear being held responsible for reporting under these timeframes or encourage overreporting. TMA recommended against HHSC adopting the proposed reporting timeframe requirements or any finite reporting time limits. TMA also recommended HHSC revert to the "as soon as possible" language stated in HSC §161.132.

Response: HHSC revises §510.46(c)(3)(A) and (B) by removing the 24- and 48-hour reporting timeframe requirements.

Comment: DRTx and TCDD recommended HHSC revise §510.46(e) by adding the HHSC Complaint Intake toll-free number.

Response: HHSC declines to add the toll-free number in §510.46(e) because it is subject to change, leaving an incorrect number in the rule until updated, but revises §510.46(a) to clarify HHSC Complaint and Incident Intake is the appropriate HHSC contact for complaints related to abuse, neglect, and exploitation and illegal, unethical, and unprofessional conduct.

Comment: Regarding §510.46(f)(1), DRTx recommended HHSC revise §510.46(f)(1)(A) and §510.46(f)(1)(B) to ensure the reporter is advised of any appeals process. TCDD recommended HHSC revise §510.46(f)(1)(A) to ensure the reporter is advised of any appeals process and §510.46(f)(1)(B) to ensure

the alleged victim, alleged victim's parent or guardian is also advised of any appeals process.

Response: HHSC declines to revise §510.46(f) at this time because this revision is beyond the scope of this rule project.

Comment: Regarding §510.46(g)(4), CCHR recommended HHSC revise §510.46(g)(4) to clarify HHSC will not investigate a complaint containing allegations that are not a violation of the HSC, including Chapters 571 through 578, Chapter 161.132, 321, 322, or 26 TAC Chapter 510 but shall be referred to law enforcement agencies or other agencies, as appropriate. TCDD stated §510.46(g)(4) lacks language that makes clear that law enforcement should be contacted immediately given that abuse, neglect, and sexual abuse are criminal matters and recommended HHSC revise §510.46(g)(4) to clarify what the proposed §510.46(g)(4) means.

Response: HHSC declines to revise §510.46(g)(4) at this time because these revisions are beyond the scope of this rule project.

Comment: IAPMO recommended HHSC consider adopting the 2024 National Standard Plumbing Code (NSPC) in Subchapter G of this chapter.

Response: HHSC declines to revise Subchapter G at this time because this revision is beyond the scope of this rule project. HHSC notes the agency may incorporate the 2024 NSPC into future rule projects.

Comment: IAPMO recommended HHSC revise §510.122(d)(4) and §510.123 (d)(4)(B) to update the references to the National Association of Plumbing-Heating-Cooling Contractors (PHCC) to the International Association of Plumbing and Mechanical Officials (IAPMO) because PHCC transferred ownership of the National Standard Plumbing Code to IAPMO in 2017, and therefore references to PHCC are outdated.

Response: HHSC revises §510.122(d)(4) and §510.123(d)(4)(B) by replacing PHCC with IAPMO.

SUBCHAPTER A. GENERAL PROVISIONS

26 TAC §510.1, §510.2

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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

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SUBCHAPTER B. APPLICATION AND ISSUANCE OF A LICENSE

26 TAC §§510.21 - 510.26

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER C. OPERATIONAL REQUIREMENTS

26 TAC §§510.41 - 510.43, 510.46

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.46. Abuse and Neglect Issues.

(a) Reporting. Incidents of abuse, neglect, exploitation, or illegal, unethical or unprofessional conduct shall be reported to Texas Health and Human Services Commission (HHSC) Complaint and Incident Intake as provided in subsections (b) and (c) of this section.

(b) Abuse or neglect of a child, and abuse, neglect, or exploitation of an elderly or disabled person. The following definitions apply only to this subsection.

(1) Abuse or neglect of a child, as defined in 25 TAC §1.204(a) and (b) (relating to Abuse, Neglect, and Exploitation Defined).

(2) Abuse, neglect, or exploitation of an elderly or disabled person, as defined in 25 TAC §1.204(a) - (c).

(c) Abuse and neglect of individuals with mental illness, and illegal, unethical, and unprofessional conduct. The requirements of this subsection are in addition to the requirements of subsection (b) of this section.

(1) Definitions. The following definitions are in accordance with Texas Health and Safety Code (HSC) §161.131 and apply only to this subsection.

(A) Abuse--

(i) Abuse (as the term is defined in United States Code (USC) Title 42 Chapter 114 is any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as:

(I) the rape or sexual assault of an individual with mental illness;

(II) the striking of an individual with mental illness;

(III) the use of excessive force when placing an individual with mental illness in bodily restraints; and

(IV) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with federal and state laws and regulations.

(ii) In accordance with HSC §161.132(j), abuse also includes coercive or restrictive actions that are illegal or not justified by the patient's condition and that are in response to the patient's request for discharge or refusal of medication, therapy, or treatment.

(B) Illegal conduct--Illegal conduct (as the term is defined in HSC §161.131(4)) is conduct prohibited by law.

(C) Neglect--Neglect (as the term is defined in 42 USC §10801 et seq.) is a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

(D) Unethical conduct--Unethical conduct (as the term is defined in HSC §161.131(11)) is conduct prohibited by the ethical standards adopted by state or national professional organizations for their respective professions or by rules established by the state licensing agency for the respective profession.

(E) Unprofessional conduct--Unprofessional conduct (as the term is defined in HSC §161.131(12)) is conduct prohibited under rules adopted by the state licensing agency for the respective profession.

(2) Posting requirements. A facility shall prominently and conspicuously post for display in a public area that is readily visible to patients, residents, volunteers, employees, and visitors a statement of the duty to report abuse and neglect, or illegal, unethical or unprofessional conduct in accordance with HSC §161.132(e). The statement shall be in English and in a second language appropriate to the demographic makeup of the community served and contain the number of the current toll-free telephone number for submitting a complaint to HHSC as specified on the HHSC website.

(3) Reporting responsibility.

(A) Reporting abuse and neglect. A person, including an employee, volunteer, or other person associated with the facility who reasonably believes or who knows of information that would reasonably cause a person to believe that the physical or mental health or welfare of a patient of the facility who is receiving mental health or chemical dependency services has been, is, or will be adversely affected by abuse or neglect (as those terms are defined in this subsection) by any person shall as soon as possible, report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(a).

(B) Reporting illegal, unprofessional, or unethical conduct. An employee of or other person associated with a facility including a health care professional, who reasonably believes or who knows of information that would reasonably cause a person to believe that the facility or an employee or health care professional associated with the facility, has, is, or will be engaged in conduct that is or might be illegal, unprofessional, or unethical and that relates to the operation of the facility or mental health or chemical dependency services provided in the facility shall as soon as possible, report the information supporting the belief to HHSC or to the appropriate state health care regulatory agency in accordance with HSC §161.132(b).

(4) Training requirements. A facility providing mental health or substance use services shall comply with §568.121 of this title (relating to Staff Member Training) to all employees and associated health care professionals who are assigned to or who provide services in the facility.

(d) Investigations. A complaint under this subsection will be investigated or referred by HHSC as follows.

(1) Allegations under subsection (b) of this section will be investigated in accordance with 25 TAC §1.205 (relating to Reports and Investigations) and 25 TAC §1.206 (relating to Completion of Investigation).

(2) Allegations under subsection (c) of this section will be investigated in accordance with §510.83 of this chapter (relating to Complaint Investigations). Allegations concerning a health care professional's failure to report abuse and neglect or illegal, unprofessional, or unethical conduct will not be investigated by HHSC but will be referred to the individual's licensing board for appropriate disciplinary action.

(3) Allegations under both subsections (b) and (c) will be investigated in accordance with 25 TAC §§1.205 and 1.206 except as noted in paragraph (2) of this subsection concerning a health care professional's failure to report.

(e) Submission of complaints. A complaint made under this section shall be submitted in writing or orally to HHSC.

(f) Notification.

(1) For complaints under subsection (b) of this section, HHSC shall provide notification according to the following:

(A) HHSC shall notify the reporter, if known, in writing of the outcome of the complete investigation.

(B) HHSC shall notify the alleged victim, and the alleged victim's parent or guardian if a minor, in writing of the outcome of the completed investigation.

(2) For complaints under subsection (c) of this section, HHSC shall inform, in writing, the complainant who identifies themselves by name and address of the following:

(A) the receipt of the complaint;

(B) if the complainant's allegations are potential violations of this chapter warranting an investigation;

(C) whether the complaint will be investigated by HHSC;

(D) whether and to whom the complaint will be referred; and

(E) the findings of the complaint investigation.

(g) HHSC reporting and referral.

(1) Reporting health care professional to licensing board.

(A) In cases of abuse, neglect, or exploitation, as those terms are defined in subsection (b), by a licensed, certified, or registered health care professional, HHSC may forward a copy of the completed investigative report to the state agency which licenses, certifies or registers the health care professional. Any information which might reveal the identity of the reporter or any other patients or clients of the facility must be blacked out or deidentified.

(B) A health care professional who fails to report abuse and neglect or illegal, unprofessional, or unethical conduct as required by subsection (c)(3) of this section may be referred by HHSC to the individual's licensing board for appropriate disciplinary action.

(2) Sexual exploitation reporting requirements. In addition to the reporting requirements described in subsection (c)(3) of this section, a mental health services provider must report suspected sexual exploitation in accordance with Texas Civil Practice and Remedies Code §81.006.

(3) Referral follow-up. HHSC shall request a report from each referral agency of the action taken by the agency six months after the referral.

(4) Referral of complaints. A complaint containing allegations which are not a violation of HSC Chapters 571 through 577 or this chapter will not be investigated by HHSC but shall be referred to law enforcement agencies or other agencies, as appropriate.

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SUBCHAPTER D. VOLUNTARY AGREEMENTS

26 TAC §510.61, §510.62

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER F. FIRE PREVENTION AND SAFETY REQUIREMENTS

26 TAC §510.101

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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SUBCHAPTER G. PHYSICAL PLANT AND CONSTRUCTION REQUIREMENTS

26 TAC §§510.121 - 510.123, 510.125, 510.127 - 510.129, 510.131

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and HSC §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.122. New Construction Requirements.

(a) Facility location. Any proposed new facility shall be easily accessible to the community and to service vehicles such as delivery trucks, ambulances, and fire protection apparatus. No building may be converted for use as a facility which, because of its location, physical condition, state of repair, or arrangement of facilities, would be hazardous to the health and safety of the patients.

(1) Hazardous locations.

(A) Underground and above ground hazards. New facilities or additions to existing facilities shall not be built within 125 feet of right away/easement of hazardous locations including underground liquid butane or propane, liquid petroleum or natural gas transmission lines, high pressure lines, and not under high voltage electrical lines.

(B) Fire hazards. New facilities shall not be built within 300 feet of above ground or underground storage tanks containing liquid petroleum or other flammable liquids used in connection with a bulk plant, marine terminal, aircraft refueling, bottling plant of a liquefied petroleum gas installation, or near other hazardous or hazard producing plants.

(2) Undesirable locations.

(A) Nuisance producing sites. New facilities shall not be located near nuisance producing industrial sites, feed lots, sanitary landfills, or manufacturing plants producing excessive noise or air pollution.

(B) Cemeteries. New facilities shall not be located near a cemetery in a manner that allows direct view of the cemetery from patient windows.

(C) Flood plains. Construction of new facilities shall be avoided in designated flood plains. Where such is unavoidable, access and required functional facility components shall be constructed above the designated flood plain. This requirement also applies to new additions to existing facilities or portions of facilities which have been licensed previously as facilities but which have been vacated or used for purposes other than facilities. This requirement does not apply to remodeling of existing licensed facilities.

(D) Airports. Construction of new facilities shall be avoided in close proximity to airports. When facilities are proposed to be located near airports, recommendations of the Texas Aviation Authority and the Federal Aviation Authority shall apply. A facility may not be constructed within a rectangular area formed by lines perpendicular to and two miles (10,560 feet) from each end of any runway and by lines parallel to and one-half mile (2,640 feet) from each side of any runway.

(b) Environmental considerations. Development of a facility site and facility construction shall be governed by state and local regulations and requirements with respect to the effect of noise and traffic on the community and the environmental impact on air and water.

(c) Facility site.

(1) Paved roads and walkways. Paved roads shall be provided within the lot lines to provide access from public roads to the main entrance, entrances serving community activities, and to service entrances, including loading and unloading docks for delivery trucks. Finished surface walkways shall be provided for pedestrians.

(2) Parking. Off-street parking shall be available for visitors, employees, and staff. Parking structures directly accessible from a facility shall be separated with two-hour fire rated noncombustible construction. When used as required means of egress for facility occupants, parking structures shall comply with National Fire Protection Association 88A, Standard for Parking Structures, 1998 edition. This requirement does not apply to freestanding parking structures.

(A) Number of parking places. In the absence of a formal parking study, one parking space shall be provided for each day shift employee plus one space for one and one-half patient beds. This ratio may be reduced in an area convenient to a public transportation system or to public parking facilities on the basis of a formal parking study. Parking shall be increased accordingly when the size of an existing facility is increased.

(B) Additional parking. Additional parking shall be required to accommodate medical staff, outpatient and other services when such services are provided.

(C) Delivery parking. Separate parking facilities shall be provided for delivery vehicles.

(D) Accessible parking. Parking spaces for persons with disabilities shall be provided in accordance with the Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 United States Code, Chapter 126, and Title 36 Code of Federal Regulations, Part 1191, Appendix A, Accessibility Guidelines for Buildings and Facilities.

(d) Building design and construction requirements. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with accepted engineering practices and standards and the local governing building codes. Where there is no local governing building code, one of the following codes shall be adhered to: Uniform Building Code, 1999 edition, published by the International Conference of Building Officials.

(1) General architectural requirements. All new construction, including conversion of an existing building to a facility, establishing a separately licensed facility in a building with an existing licensed health care occupancy, and establishing a licensed facility in a non-health care occupancy shall comply with Chapter 18 of the National Fire Protection Association 101, Code for Safety to Life from Fire in Buildings and Structures, 2000 edition (NFPA 101), and Subchapters F and G of this chapter (relating to Fire Prevention and Safety Requirements and Physical Plant and Construction Requirements, respectively). The facility shall comply with the requirements of this paragraph and any specific architectural requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter (relating to Spatial Requirements for New Construction).

(A) Special design provisions. Special provisions shall be made in the design of a facility in regions where local experience shows loss of life or extensive damage to buildings resulting from hurricanes, tornadoes, or floods.

(B) Foundations. Foundations shall rest on natural solid bearing if satisfactory bearing is available. Proper soil-bearing values shall be established in accordance with recognized requirements. If solid bearing is not encountered at practical depths, the structure shall be supported on driven piles or drilled piers designed to support the intended load without detrimental settlement, except that one-story buildings may rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be done under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certification of compliance with the job specifications. All footings shall extend to a depth not less than one foot below the estimated maximum frost line.

(C) Physical environment. A physical environment that protects the health and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and subchapters F and G of this chapter.

(D) Construction type. A facility may occupy an entire building or a portion of a building, provided the facility portion of the building is separated from the rest of the building in accordance with subparagraph (E) of this paragraph and the entire building or the facility portion of the building complies with new construction requirements (type of construction permitted for facilities by NFPA 101, §18-1.6.2), and the entire building is protected with a fire sprinkler system conforming with requirements of National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 1999 Edition (NFPA 13).

(E) Separate buildings. Portions of a building divided horizontally with two-hour fire rated walls which are continuous (without offsets) from the foundation to above the roof shall be considered as a separate building. Communicating openings in the two-hour wall shall be limited to public spaces such as lobbies and corridors. All such openings shall be protected with self-closing one and one-half hour, Class B fire door assemblies.

(F) Design for people with disabilities. Special considerations benefiting staff, visitors, and patients with disabilities shall be provided. Each facility shall comply with the Americans with Disabilities Act (ADA) of 1990, Public Law 101-336, 42 United States Code, Chapter 126, and Title 36 Code of Federal Regulations, Part 1191, Appendix A, Accessibility Guidelines for Buildings and Facilities.

(G) Other regulations. Certain projects may be subject to other regulations, including those of federal, state, and local authorities. The more stringent standard or requirement shall apply when a difference in requirements for construction exists.

(H) Exceeding minimum requirements. Nothing in this subchapter shall be construed to prohibit a better type of building construction, more exits, or otherwise safer conditions than the minimum requirements specified in this subchapter.

(I) Equivalency. Nothing in this subchapter is intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this subchapter, providing technical documentation which demonstrates equivalency is submitted to the department for approval.

(J) Freestanding buildings (not for patient use). Separate freestanding buildings for nonpatient use such as the heating plant, boiler plant, laundry, repair workshops, or general storage may be of unprotected non-combustible construction, protected non-combustible construction, or fire-resistive construction and be designed in accordance with other occupancy classifications requirements listed in NFPA 101.

(K) Freestanding buildings (for patient use other than sleeping). Buildings containing areas for patient use which do not contain patient sleeping areas and in which care or treatment is rendered to ambulatory inpatients who are capable of judgment and appropriate physical action for self-preservation under emergency conditions, may be classified as ambulatory health care occupancies or business occupancies as listed in NFPA 101 Chapters 20 and 38, respectively, instead of facility occupancy. Such buildings shall be located at least 20 feet from the facility unless protected by an approved automatic sprinkler system.

(L) Energy conservation. In new construction and in major alterations and additions to existing buildings and in new buildings, electrical and mechanical components shall be selected for efficient utilization of energy.

(2) General detail and finish requirements. Details and finishes in new construction projects, including additions and alterations, shall be in compliance with this paragraph, with NFPA 101, Chapter 18, with local building codes, and with any specific detail and finish requirements for the particular unit or suite as contained in §510.123 of this subchapter.

(A) General detail requirements.

(i) Fire safety. Fire safety features, including compartmentation, means of egress, automatic extinguishing systems, inspections, smoking regulations, and other details relating to fire prevention and fire protection shall comply with §510.121 of this subchapter (relating to Requirements for Buildings in which Existing Licensed Facilities are Located), and NFPA 101 Chapter 18 requirements for facilities. The Fire Safety Evaluation System for Health Care Occupancies contained in the National Fire Protection Association 101A, Alternative Approaches to Life Safety, 1998 edition, Chapter 3, shall not be used in new building construction, renovations, or additions to existing facilities.

(ii) Access to exits. Corridors providing access to all patient, diagnostic, treatment, and sleeping rooms and exits shall be at least six feet in clear and unobstructed width (except as allowed by NFPA 101, §18-2.3.3, Exceptions 1 and 2), not less than 7 feet 6 inches in height, and constructed in accordance with requirements listed in NFPA 101 §18-3.6.

(iii) Corridors in other occupancies. Public corridors in outpatient, administrative, and service areas which are designed to other than facility requirements and are the required means of egress from the facility shall be not less than five feet in width.

(iv) Encroachment into the means of egress. Items such as drinking fountains, telephone booths or stations, and vending machines shall be so located as to not project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum. Portable equipment shall not be stored so as to project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum.

(v) Doors in means of egress. All door leaves in the means of egress shall be not less than 36 inches wide or as otherwise permitted for facilities by NFPA 101 §18-2.3.5.

(vi) Sliding doors. When sliding doors are provided to a means of egress corridor, the sliding doors shall have break-away

provisions, positive latching devices, and shall be installed to resist passage of smoke.

(vii) Control doors. Designs that include cross-corridor control doors should be avoided. When unavoidable, cross-corridor control doors shall consist of two 32-inch wide leaves which swing in a direction opposite from the other, or of the double acting type, and be provided with view panels.

(viii) Emergency access. Rooms containing bathtubs, showers, or water closets, intended for patient use shall be provided with at least one outswinging door or special frame and hardware which will permit the door to swing out for staff access to a patient who may have collapsed against the door. The width of such doors shall not be less than 36 inches.

(ix) Obstruction of corridors. All doors which swing towards the corridor must be recessed. Corridor doors to rooms not subject to occupancy (any room that you can walk into and close the door behind you is considered occupiable) may swing into the corridor, provided that such doors comply with the requirements of NFPA 101 §7-2.1.4.3.

(x) Stair landing. Doors shall not open immediately onto a stair without a landing. The landing shall be 44 inches deep or have a depth at least equal to the door width, whichever is greater.

(xi) Doors to rooms subject to occupancy. All doors to rooms subject to occupancy shall be of the swing type except that horizontal sliding doors complying with the requirements of NFPA 101 §18-2.2.2.9 are permitted. Door leaves to rooms subject to occupancy shall not be less than 36 inches wide unless noted otherwise.

(xii) Operable windows and exterior doors. Windows that can be opened without tools or keys and outer doors without automatic closing devices shall be provided with insect screens.

(xiii) Glazing. Glass doors, lights, sidelights, borrowed lights, and windows located within 12 inches of a door jamb or with a bottom-frame height of less than 18 inches and a top-frame height of more than 36 inches above the finished floor which may be broken accidentally by pedestrian traffic shall be glazed with safety glass or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials shall be used for wall openings in activity areas such as recreation and exercise rooms, unless otherwise required for fire safety. Safety glass, tempered or plastic glazing materials shall be used for shower doors and bath enclosures, interior windows and doors. Plastic and similar materials used for glazing shall comply with the flame-spread ratings of NFPA 101 §18-3.3.

(xiv) Fire doors. All fire doors shall be listed by an independent testing laboratory and shall meet the construction requirements for fire doors in National Fire Protection Association 80, Standard for Fire Doors and Fire Windows, 1999 edition. Reference to a labeled door shall be construed to include labeled frame and hardware.

(xv) Elevator doors. Elevator shaft openings shall be protected with a B labeled one-hour fire protection rated doors in buildings less than four stories; and one and one-half hour fire protection rated doors in buildings four or more stories.

(xvi) Elevator lobbies. Elevator lobbies shall have at least 10 feet of clear floor space in front of the elevator doors.

(xvii) Grab bars. Grab bars shall be provided at patient toilets, showers and tubs. The bars shall have sufficient strength and anchorage to sustain a concentrated vertical or horizontal load of 250 pounds. Grab bars are not permitted at bathing and toilet fixtures unless designed and installed to eliminate the possibility of patients harming themselves. Grab bars intended for use by persons with a disability shall also comply with ADA requirements.

(xviii) Soap dishes. Recessed soap dishes shall be provided at all showers and bathtubs.

(xix) Hand washing facilities. Location and arrangement of fittings for hand washing facilities shall permit their proper use and operation. Hand washing fixtures with hands-free operable controls shall be provided within each procedure room, workroom, examination and treatment room and all toilet rooms unless noted otherwise. Hands-free includes blade-type handles, and foot, knee, or sensor operated controls. Particular care shall be given to the clearances required for blade-type operating handles. Lavatories and hand washing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture. In addition to the specific areas noted, hand washing facilities shall be provided and conveniently located for staff use throughout the facility where patient care and services are provided.

(xx) Hand drying. Provisions for hand drying shall be included at all hand washing facilities except scrub sinks. There shall be hot air dryers or individual paper or cloth units enclosed in such a way as to provide protection against dust or soil and ensure single unit dispensing.

(xxi) Mirrors. Mirrors shall not be installed at hand washing fixtures where asepsis control and sanitation requirements would be lessened by hair combing.

(xxii) Ceiling heights. The minimum ceiling height shall be eight feet with the following exceptions.

(I) Minor rooms. Ceilings in storage rooms, toilet rooms, and other minor rooms shall be not less than 7 feet 6 inches.

(II) Boiler rooms. Boiler rooms shall have ceiling clearances not less than 2 feet 6 inches above the main boiler header and connecting piping.

(III) Overhead clearance. Suspended tracks, rails, pipes, signs, lights, door closers, exit signs, and other fixtures that protrude into the path of normal traffic shall not be less than 6 feet 8 inches above the finished floor.

(xxiii) Areas producing impact noises. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed area unless special provisions are made to minimize noise.

(xxiv) Noise reduction. Noise reduction criteria in accordance with the Table 1 in §510.131(a) of this subchapter (relating to Tables) shall apply to partitions, floor, and ceiling construction in patient areas.

(xxv) Rooms with heat producing equipment. Rooms containing heat-producing equipment such as heater rooms, laundries, etc. shall be insulated and ventilated to prevent any occupied floor surface above from exceeding a temperature differential of 10 degrees Fahrenheit above the ambient room temperature.

(xxvi) Chutes. Linen and refuse chutes shall comply with the requirements of National Fire Protection Association 82, Standard on Incinerators and Waste and Linen Handling Systems and Equipment, 1999 edition, and NFPA 101 §18-5.4.

(xxvii) Thresholds and expansion joint covers. Thresholds and expansion joint covers shall be flush with the floor surface to facilitate the use of wheelchairs and carts. Expansion and seismic joints shall be constructed to restrict the passage of smoke and fire and shall be listed by a nationally recognized testing laboratory.

(xxviii) Housekeeping room.

(I) In addition to the housekeeping rooms required in certain suites, sufficient housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment.

(II) Each housekeeping room shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(xxix) Public toilets. In addition to the public toilets required for the main lobby, a public toilet shall be provided convenient to each public and visitor waiting area. This may be a single unisex toilet for small waiting areas.

(B) General finish requirements.

(i) Cubicle curtains and draperies.

(I) Cubicle curtains, draperies and other hanging fabrics shall be noncombustible or flame retardant and shall pass both the small scale and the large scale tests of National Fire Protection Association 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films, 1999 edition. Copies of laboratory test reports for installed materials shall be submitted to the Texas Health and Human Services Commission at the time of the final construction inspection.

(II) Cubicle curtains shall be provided to assure patient privacy.

(ii) Flame spread, smoke development and noxious gases. Flame spread and smoke developed limitations of interior finishes shall comply with Table 2 of §510.131(b) of this subchapter and NFPA 101 §10-2.1. The use of materials known to produce large or concentrated amounts of noxious or toxic gases shall not be used in exit accesses or in patient areas. Copies of laboratory test reports for installed materials tested in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 edition, and National Fire Protection Association 258, Standard Research Test Method for Determining Smoke Generation of Solid Materials, 1997 edition, shall be provided.

(iii) Floor finishes. Flooring shall be easy to clean and have wear resistance appropriate for the location involved. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a nonslip surface. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. The following are acceptable floor finishes:

(I) painted concrete;

(II) vinyl and vinyl composition tiles and sheets;

(III) monolithic or seamless flooring:

(-a-) where required, seamless flooring shall be impervious to water, coved, and installed integral with the base, tightly sealed to the wall, and without voids that can harbor insects or retain dirt particles; and

(-b-) welded joint flooring is acceptable;

(IV) ceramic and quarry tile;

(V) wood floors;

(VI) carpet flooring, which if installed in patient rooms and similar patient care areas, shall be treated to prevent bacterial and fungal growth;

(VII) terrazzo; and

(VIII) poured in place floors.

(iv) Wall finishes. Wall finishes shall be smooth, washable, moisture resistant, and cleanable by standard housekeeping practices. Wall finishes shall comply with requirements contained in Table 2 of §510.131(b) of this subchapter and NFPA 101 §18-3.3.

(I) Wall finishes shall be water resistant in the immediate area of plumbing fixtures.

(II) Wall finishes in areas subject to frequent wet cleaning methods shall be impervious to water, tightly sealed and without voids.

(v) Floor, wall and ceiling penetrations. Floor, wall, and ceiling penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of dirt particles, rodents, and insects. Joints of structural elements shall be similarly sealed.

(vi) Ceiling types. All occupied rooms and spaces shall be provided with finished ceilings. Ceilings which are a part of a rated roof or ceiling assembly or a floor or ceiling assembly shall be constructed of listed components and installed in accordance with the listing. Three types of ceilings that are required in various areas of the facility are the following.

(I) Ordinary ceilings. Ceilings such as acoustical tiles installed in a metal grid which are dry cleanable with equipment used in daily housekeeping activities such as dusters and vacuum cleaners.

(II) Washable ceilings. Ceilings that are made of washable, smooth, moisture impervious materials such as painted lay-in gypsum wallboard or vinyl faced acoustic tile in a metal grid.

(III) Monolithic ceilings. Ceilings which are monolithic from wall to wall (painted solid gypsum wallboard), smooth and without fissures, open joints, or crevices and with a washable and moisture impervious finish.

(vii) Special construction. Special conditions may require special wall and ceiling construction for security in areas such as storage of controlled substances and areas where patients are likely to attempt suicide or escape.

(viii) Materials finishes. Materials known to produce noxious gases when burned shall not be used for mattresses, upholstery, and wall finishes.

(3) General mechanical requirements. This paragraph contains common requirements for mechanical systems; steam and hot and cold water systems; air-conditioning, heating and ventilating systems; plumbing fixtures; piping systems; and thermal and acoustical insulation. The facility shall comply with the requirements of this paragraph and any specific mechanical requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter.

(A) Cost. All mechanical systems shall be designed for overall efficiency and life cycle costing, including operational costs. Recognized engineering procedures shall be followed to achieve the most economical and effective results. In no case shall patient care or safety be sacrificed for conservation.

(B) Equipment location. Mechanical equipment may be located indoors or outdoors (when in a weatherproof enclosure), or in separate buildings.

(C) Vibration isolation. Mechanical equipment shall be mounted on vibration isolators as required to prevent unacceptable structure-borne vibration. Ducts, pipes, etc. connected to mechanical equipment which is a source of vibration shall be isolated from the equipment with vibration isolators.

(D) Performance and acceptance. Prior to completion and acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or the design engineer's representative that the installation and performance of these systems conform to the requirements of the plans and specifications.

(i) Material lists. Upon completion of the contract, the owner shall be provided with parts lists and procurement information with numbers and description for each piece of equipment.

(ii) Instructions. Upon completion of the contract, the owner shall be provided with instructions in the operational use of systems and equipment as required.

(E) Heating, ventilating and air conditioning (HVAC) systems. All HVAC systems shall comply with and shall be installed in accordance with the requirements of National Fire Protection Association 90A, Standard for the Installation of Air Conditioning and Ventilating Systems, 1999 edition, (NFPA 90A), NFPA 99, Chapter 5, the requirements contained in this subparagraph, and the specific requirements for a particular unit in accordance with §510.123 of this subchapter.

(i) General ventilation requirements. All rooms and areas in the facility listed in Table 3 of §510.131(c) of this subchapter shall have provision for positive ventilation. Fans serving exhaust systems shall be located at the discharge end and shall be conveniently accessible for service. Exhaust systems may be combined, unless otherwise noted, for efficient use of recovery devices required for energy conservation. The ventilation rates shown in Table 3 of §510.131(c) of this subchapter shall be used only as minimum requirements since they do not preclude the use of higher rates that may be appropriate. Supply air to the building and exhaust air from the building shall be regulated to provide a positive pressure within the building with respect to the exterior.

(I) Cost reduction methods. To reduce utility costs, the building design and systems proposed shall utilize energy conserving procedures including recovery devices, variable air volume, load shedding, systems shut down or reduction of ventilation rates (when specifically permitted) in certain areas when unoccupied, insofar as patient care is not jeopardized.

(II) Economizer cycle. Mechanical ventilation shall be arranged to take advantage of outside air supply by using an economizer cycle when appropriate to reduce heating and cooling systems loads. Innovative design that provides for additional energy conservation while meeting the intent of this section for acceptable patient care will be considered.

(III) Outside air intake locations. Outside air intakes shall be located at least 25 feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents, or areas which may collect vehicular exhaust or other noxious fumes. (Prevailing winds and proximity to other structures may require other arrangements.) Plumbing and vacuum vents that terminate five feet above the level of the top of the air intake may be located as close as 10 feet.

(IV) Low air intake location limit. The bottom of outside air intakes serving central systems shall be located as high as practical but at least six feet above ground level, or if installed above the roof, three feet above the roof level.

(V) Contaminated air exhaust outlets. Exhaust outlets from areas (kitchen hoods, ethylene oxide sterilizers, etc.) that exhaust contaminated air shall be above the roof level and arranged to exhaust upward.

(VI) Directional air flow. Ventilation systems shall be designed and balanced to provide directional flow as shown in Table 3 of §510.131(c) of this subchapter. For reductions and shut down of ventilation systems when a room is unoccupied, the provisions in Note 4 of Table 3 of §510.131(c) of this subchapter shall be followed.

(VII) Areas requiring fully ducted systems. Fully ducted supply, return and exhaust air for HVAC systems shall be provided for all general patient care areas and where required for fire safety purposes. Combination systems, utilizing both ducts and plenums for movement of air in these areas shall not be permitted. Such areas include isolation rooms and food preparation areas.

(VIII) Ventilation start-up requirements. Air handling systems shall not be started up and operated without the filters installed in place. This includes the 90% efficiency filters where required. Ducts shall be cleaned thoroughly by an air duct cleaning contractor when the air handling systems have been operating without the required filters in place.

(IX) Humidifier location. When duct humidifiers are located upstream of the final filters, they shall be located at least 15 feet from the filters. Ductwork with duct-mounted humidifiers shall be provided with a means of removing water accumulation. An adjustable high-limit humidistat shall be located downstream of the humidifier to reduce the potential of condensation inside the duct. All duct take-offs should be sufficiently downstream of the humidifier to ensure complete moisture absorption. Reservoir-type water spray or evaporative pan humidifiers shall not be used.

(ii) Filtration requirements. All central air handling systems serving patient care areas, including nursing unit corridors, shall be equipped with filters having efficiencies equal to, or greater than, those specified for those types of areas in Table 4 of §510.131(d) of this subchapter. Filter efficiencies shall be average efficiencies tested in accordance with American Society of Heating, Refrigerating, and Air-conditioning Engineers (ASHRAE), Inc., Standard 52, 1999 edition. All joints between filter segments and between filter segments and the enclosing ductwork, shall have gaskets and seals to provide a positive seal against air leakage. Air handlers serving more than one room shall be considered as central air handlers.

(I) Filtration requirements for air handling units serving single rooms requiring asepsis control. Dedicated air handlers serving only one room where asepsis control is required, including operating rooms, delivery rooms, special procedure rooms, and nurseries shall be equipped with filters having efficiencies equal to, or greater than, those specified for patient care areas in Table 4 of §510.131(d) of this subchapter.

(II) Filtration requirements for air handling units serving other single rooms. Dedicated air handlers serving all other single rooms shall be equipped with nominal filters installed at the return air grille.

(III) Location of multiple filters. Where two filter beds are required by Table 4 of §510.131(d) of this subchapter, filter bed number one shall be located upstream of the air-conditioning equipment and filter bed number two shall be downstream of the supply fan or blowers.

(IV) Location of single filters. Where only one filter bed is required by Table 4 of §510.131(d) of this subchapter, it shall be located upstream of the supply fan. Filter frames shall be durable and constructed to provide an airtight fit with the enclosing ductwork.

(V) Pressure monitoring devices. A manometer or draft gauge shall be installed across each filter bed having a required efficiency of 75% or more including hoods requiring high efficiency particulate air (HEPA) filters.

(iii) Thermal and acoustical insulation for air handling systems. Asbestos insulation shall not be used.

(I) Thermal duct insulation. Air ducts and casings with outside surface temperature below ambient dew point or temperature above 80 degrees Fahrenheit shall be provided with thermal insulation.

(II) Insulation in air plenums and ducts. Linings in air ducts and equipment shall meet the Erosion Test Method described in Underwriters Laboratories, Inc., Standard Number 181.

(III) Insulation flame spread and smoke developed ratings. Interior and exterior insulation, including finishes and adhesives on the exterior surfaces of ducts and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 50 or less as required by NFPA 90A Chapters 2 and 3.

(IV) Linings and acoustical traps. Duct lining and acoustical traps exposed to air movement shall not be used in ducts serving critical care areas. This requirement shall not apply to mixing boxes and acoustical traps that have approved nonabrasive coverings over such linings.

(V) Frangible insulation. Insulation of soft and spray-on types shall not be used where it is subject to air currents or mechanical erosion or where loose particles may create a maintenance problem.

(VI) Existing duct linings. Internal linings shall not be used in ducts, terminal boxes, or other air system components supplying operating rooms, delivery rooms, birthing rooms, labor rooms, recovery rooms, nurseries, trauma rooms, isolation rooms, and intensive care units unless terminal filters of at least 90% efficiency are installed downstream of linings.

(iv) Fire damper requirements. Fire dampers shall be located and installed in all ducts at the point of penetration of a two-hour or higher fire rated wall or floor in accordance with the requirements of NFPA 101 §18-5.2.

(v) Smoke damper requirements. Smoke dampers shall be located and installed in accordance with the requirements of NFPA 101 §18-3.7.3, and NFPA 90A Chapter 3.

(I) Fail-safe installation. Smoke dampers shall close on activation of the fire alarm system by smoke detectors installed and located as required by National Fire Protection Association 72, National Fire Alarm Code, 1999 edition (NFPA 72), Chapter 5; NFPA 90A, Chapter 4; and NFPA 101, §18-3.7; the fire sprinkler system; and upon loss of power. Smoke dampers shall not close by fan shut-down alone.

(II) Interconnection of air handling fans and smoke dampers. Air handling fans and smoke damper controls may be interconnected so that closing of smoke dampers will not damage the ducts.

(III) Frangible devices. Use of frangible devices for shutting smoke dampers is not permitted.

(vi) Acceptable damper assemblies. Only fire damper and smoke damper assemblies integral with sleeves and listed for the intended purpose shall be acceptable.

(vii) Duct access doors. Unobstructed access to duct openings in accordance with NFPA 90A §2-3.4, shall be provided in ducts within reach and sight of every fire damper, smoke damper and smoke detector. Each opening shall be protected by an internally insulated door which shall be labeled externally to indicate the fire protection device located within.

(viii) Restarting controls. Controls for restarting fans may be installed for convenient fire department use to assist in evacuation of smoke after a fire is controlled, provided that provisions are made to avoid possible damage to the system because of closed dampers. To accomplish this, smoke dampers shall be equipped with remote control devices.

(ix) Make-up air. If air supply requirements in Table 3 of §510.131(c) of this subchapter do not provide sufficient air for use by exhaust hoods and safety cabinets, filtered make-up air shall be ducted to maintain the required air flow direction in that room. Make-up systems for hoods shall be arranged to minimize short circuiting of air and to avoid reduction in air velocity at the point of contaminant capture.

(4) General piping systems and plumbing fixture requirements. All piping systems and plumbing fixtures shall be designed and installed in accordance with the requirements of the National Standard Plumbing Code, published by the International Association of Plumbing and Mechanical Officials, 2000 edition, and this paragraph.

(A) Piping systems.

(i) Water supply systems. Water service pipe to point of entrance to the building shall be brass pipe, copper tube (not less than type M when buried directly), copper pipe, cast iron water pipe, galvanized steel pipe, or approved plastic pipe. Water distribution system piping within buildings shall be brass pipe, copper pipe, copper tube, or galvanized steel pipe. Piping systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand.

(I) Valves. Each water service main, branch main, riser, and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

(II) Backflow preventers. Backflow preventers (vacuum breakers) shall be installed on hose bibbs, laboratory sinks, janitor sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached.

(III) Flushing valves. Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers.

(IV) Capacity of water heating equipment. Water heating equipment shall have sufficient capacity to supply water for clinical, dietary and laundry use at the temperatures and amounts specified in Table 5 of §510.131(e) of this subchapter.

(V) Water temperature measurements. Water temperatures shall be measured at hot water point of use or at the inlet to processing equipment.

(VI) Water storage tanks. Water storage tanks shall be fabricated of corrosion-resistant metal or lined with noncorrosive material.

(VII) Hot water distribution. Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times.

(VIII) Emergency water supply. Emergency potable water storage shall be provided. The storage capacity shall

not be less than 500 gallons or 12 gallons per patient bed, whichever is greater. Capacity of hot water storage tanks may be included as part of the required emergency water capacity when valves and piping systems are arranged to make this water available at all times.

(ii) Fire sprinkler systems. Fire sprinkler systems shall be provided in facilities as required by NFPA 101, §18-3.5. All fire sprinkler systems shall be designed, installed, and maintained in accordance with the requirements of NFPA13, and shall be certified as required by §510.127(d)(3)(C) of this subchapter (relating to Preparation, Submittal, Review and Approval of Plans).

(iii) Nonflammable medical gas and clinical vacuum systems. Nonflammable medical gas and clinical vacuum system installations shall be designed, installed and certified in accordance with the requirements of NFPA 99, §4-3 for Level I systems and the requirements of this clause.

(I) Outlets. Nonflammable medical gas and clinical vacuum outlets shall be provided in accordance with Table 6 of §510.131(f) of this subchapter.

(II) Installer qualifications. All installations of the medical gas piping systems shall be done only by, or under the direct supervision of a holder of a master plumber license or a journeyman plumber license with a medical gas piping installation endorsement issued by the Texas State Board of Plumbing Examiners.

(III) Installer tests. Prior to closing of walls, the installer shall perform an initial pressure test, a blowdown test, a secondary pressure test, a cross-connection test, and a purge of the piping system as required by NFPA 99.

(IV) Qualifications for conducting verification tests and inspections. Verification tests and inspections by a party, other than the installer, shall be conducted by individuals who are technically competent and experienced in the field of piped medical gas systems.

(V) Verification tests. Upon completion of the installer inspections and tests and after closing of walls, verification tests of the medical gas piping systems, the warning system, and the gas supply source shall be conducted. The verification tests shall include a cross-connection test, valve test, flow test, piping purge test, piping purity test, final tie-in test, operational pressure tests, and medical gas concentration test.

(VI) Verification test requirements. Verification tests of the medical gas piping system, the warning system, shall be performed on all new piped medical gas systems, additions, renovations, or repaired portions of an existing system. All systems that are breached and components that are added, renovated, or replaced shall be inspected and appropriately tested. The breached portions of the systems subject to inspection and testing shall be all of the new and existing components in the immediate zone or area located upstream of the point or area of intrusion and downstream to the end of the system or a properly installed isolation valve.

(VII) Warning system verification tests. Verification tests of piped medical gas systems shall include tests of the source alarms and monitoring safeguards, master alarm systems, and the area alarm systems.

(VIII) Source equipment verification tests. Source equipment verification tests shall include medical gas supply sources (bulk and manifold) and the compressed air source systems (compressors, dryers, filters, and regulators).

(IX) Written certification. Upon successful completion of all verification tests, written certification for affected piped medical gas systems and piped medical vacuum systems including the supply sources and warning systems shall be provided by a party technically competent and experienced in the field of medical gas pipeline testing stating that the provisions of NFPA 99 have been adhered to and systems integrity has been achieved. The written certification shall be submitted directly to the facility and the installer. A copy shall be forwarded to HHSC by the facility.

(X) Facility responsibility. Before new piped medical gas systems, additions, renovations, or repaired portions of an existing system are put into use, the facility shall be responsible for ensuring that the gas delivered at the outlet is the gas shown on the outlet label and that the proper connecting fittings are checked against their labels.

(XI) Documentation of medical gas and clinical vacuum outlets. Documentation of the installed, modified, extended, or repaired medical gas piping system shall be submitted to HHSC by the same party certifying the piped medical gas systems. The number and type of medical gas outlets (oxygen, vacuum, medical air, nitrogen, nitrous oxide, etc.) shall be documented and arranged tabularly by room numbers and room types.

(iv) Steam and hot water systems.

(I) Boilers. Boilers shall have the capacity, based upon the net ratings as published in The I-B-R Ratings Book for Boilers, Baseboard Radiation and Finned Tube (commercial) by the Hydronics Institute Division of GAMA, to supply the normal requirements of all systems and equipment. The number and arrangement of boilers shall be such that, when one boiler breaks down or routine maintenance requires that one boiler be temporarily taken out of service, the capacity of the remaining boilers shall be sufficient to provide hot water service for clinical, dietary, and patient use, steam for sterilization and dietary purposes, and heating for emergency, recovery, treatment, and general patient rooms. However, reserve capacity for space heating of noncritical care areas (e.g. general patient rooms and administrative areas) is not required in geographical areas where a design dry bulb temperature equals 25 degrees Fahrenheit or higher as based on the 99% design value shown in the Handbook of Fundamentals, 1999 edition, published by ASHRAE, Inc.

(II) Boiler accessories. Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

(III) Valves. Supply and return mains and risers of cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends except that vacuum condensate returns need not be valved at each piece of equipment.

(v) Drainage systems.

(I) Above ground piping. Soil stacks, drains, vents, waste lines, and leaders installed above ground within buildings shall be drain-waste-vent (DWV) weight or heavier and shall be copper pipe, copper tube, cast iron pipe, or galvanized iron pipe.

(II) Underground piping. All underground building drains shall be cast iron soil pipe, hard temper copper tube (DWV or heavier), acrylonitrile-butodiene-styrene (ABS) plastic pipe (DWV Schedule 40 or heavier), polyvinyl chloride (PVC) plastic pipe (DWV Schedule 40 or heavier), or extra strength vitrified clay pipe (VCP) with compression joints or couplings with at least 12 inches of earth cover.

(III) Drains for chemical wastes. Separate drainage systems for chemical wastes (acids and other corrosive

materials) shall be provided. Materials acceptable for chemical waste drainage systems shall include chemically resistant glass pipe, high silicone content cast iron pipe, VCP, plastic pipe, or plastic lined pipe.

(IV) Drains above sensitive areas. Drainage pipes shall not be located above sensitive clean or sterile areas such as sterile processing, storage of food or of food preparation and serving areas, etc. unless protected from leaks or condensation by an approved method such as drip pans.

(V) Sewers. Building sewers shall discharge into a community sewerage system. Where such a system is not available, a facility providing sewage treatment must conform to applicable local and state regulations.

(vi) Thermal insulation for piping systems and equipment. Insulation shall be provided for the following:

(I) boilers, smoke breeching, and stacks;

(II) steam supply and condensate return piping;

(III) hot water piping and all hot water heaters, generators, converters, and storage tanks;

(IV) chilled water, refrigerant, other process piping, equipment operating with fluid temperatures below ambient dew point, and water supply and drainage piping on which condensation may occur and insulation on cold surfaces shall include an exterior vapor barrier; and

(V) other piping, ducts, and equipment as necessary to maintain the efficiency of the system.

(vii) Pipe and equipment insulation rating. Flame spread shall not exceed 25 and smoke development rating shall not exceed 150 for pipe insulation as determined by an independent testing laboratory in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 edition. Smoke development rating for pipe insulation located in environmental air areas shall not exceed 50.

(viii) Identification. All piping including heating, ventilating, air-conditioning (HVAC) shall be color coded or otherwise marked for easy identification.

(ix) Asbestos insulation. Asbestos insulation shall not be used.

(B) Plumbing fixtures. Plumbing fixtures shall be made of nonabsorptive acid-resistant materials and shall comply with the recommendations of the National Standard Plumbing Code, and this paragraph.

(i) Sink and lavatory controls. All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves which can be operated without the use of hands. Blade handles used for this purpose shall not be less than four inches in length. Single lever or wrist blade devices may be used.

(ii) Clinical sink traps. Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

(iii) Back flow or siphoning. All plumbing fixtures and equipment shall be designed and installed to prevent the back-flow or back-siphonage of any material into the water supply. The over-the-rim type water inlet shall be used wherever possible. Vacuum-breaking devices shall be properly installed when an over-the-rim type water inlet cannot be utilized.

(iv) Drinking fountain. Each drinking fountain shall be designed so that the water issues at an angle from the vertical, the end of the water orifice is above the rim of the bowl, and a guard is located over the orifice to protect it from lip contamination.

(v) Sterilizing equipment. All sterilizing equipment shall be designed and installed to prevent not only the contamination of the water supply but also the entrance of contaminating materials into the sterilizing units.

(vi) Hose attachment. No hose shall be affixed to any faucet if the end of the hose can become submerged in contaminated liquid unless the faucet is equipped with an approved, properly installed vacuum-breaker.

(vii) Bedpan washers and sterilizers. Bedpan washers and sterilizers shall be designed and installed so that both hot and cold water inlets shall be protected against back-siphonage at maximum water level.

(viii) Flood level rim clearance. The water supply spout for lavatories and sinks required in patient care areas shall be mounted so that its discharge point is a minimum of five inches above the rim of the fixture.

(ix) Floor drains or floor sinks. Where floor drains or floor sinks are installed, they shall be of a type that can be easily cleaned by removal of the cover. Removable stainless steel mesh shall be provided in addition to grilled drain cover to prevent entry of large particles of waste which might cause stoppages.

(x) Under counter piping. Under counter piping and above floor drains shall be arranged (raised) so as not to interfere with cleaning of floor below the equipment.

(xi) Ice machines. All ice making machines shall be of the self-dispensing type, unless otherwise specified.

(5) General electrical requirements. This paragraph contains common electrical requirements. The facility shall comply with the requirements of this paragraph and with any specific electrical requirements for the particular unit or suite of the facility in accordance with §510.123 of this subchapter. Electrical systems shall comply with NFPA 99 Chapter 3.

(A) Electrical installations. All new electrical material and equipment, including conductors, controls, and signaling devices, shall be installed in compliance with applicable sections of the National Fire Protection Association 70, National Electrical Code, 1999 edition (NFPA 70), and NFPA 99 and as necessary to provide a complete electrical system. Electrical systems and components shall be listed by nationally recognized listing agencies as complying with available standards and shall be installed in accordance with the listings and manufacturers' instructions.

(i) All fixtures, switches, sockets, and other pieces of apparatus shall be maintained in a safe and working condition.

(ii) Extension cords and cables shall not be used for permanent wiring.

(iii) All electrical heating devices shall be equipped with a pilot light to indicate when the device is in service, unless equipped with a temperature limiting device integral with the heater.

(iv) All equipment, fixtures, and appliances shall be properly grounded in accordance with NFPA 70.

(v) Under-counter receptacles and conduits shall be arranged (raised) to not interfere with cleaning of floor below the equipment.

(B) Installation testing and certification.

(i) Installation testing. The electrical installations, including alarm, nurses calling system and communication systems, shall be tested to demonstrate that equipment installation and operation is appropriate and functional.

(I) Grounding continuity shall be tested as described in NFPA 99 for new or existing work.

(II) A written record of performance tests on special electrical systems and equipment shall show compliance with applicable codes and standards.

(ii) Installation certification. Certifications in affidavit form signed by a registered electrical engineer attesting that the electrical service, electrical equipment, and electrical appliances have been installed in compliance with the approved plans, applicable standards, or both shall be submitted to HHSC when requested.

(C) Electrical safeguards. Shielded isolation transformers, voltage regulators, filters, surge suppressors, and other safeguards shall be provided as required where power line disturbances are likely to affect fire alarm components, data processing, equipment used for treatment, and automated laboratory diagnostic equipment.

(D) Services and switchboards. Main switchboards shall be located in separate rooms, separated from adjacent areas with one-hour fire rated enclosures containing only electrical switchgear and distribution panels and shall be accessible to authorized persons only. These rooms shall be ventilated to provide an environment free of corrosive or explosive fumes and gases, or any flammable and combustible materials. Switchboards shall be located convenient for use and readily accessible for maintenance as required by NFPA 70, Article 384. Overload protective devices shall operate properly in ambient temperatures.

(E) Panelboards. Panelboards serving normal lighting and appliance circuits shall be located on the same floor as the circuits they serve. Panelboards serving critical branch emergency circuits may serve three floors, the floor where the panelboard is located, the floor above and the floor below. Panelboards serving life safety branch circuits may serve three floors, the floor where the panelboard is located, and the floors above and below.

(i) Circuiting shall minimize the number of receptacles on a single branch circuit, in order to limit the effects of a branch circuit outage, caused by one faulted device. Any life-support equipment on that circuit would be lost.

(ii) Loading of branch circuits is limited by NFPA 70, Articles 210, 220, and 384.

(F) Wiring. All conductors for controls, equipment, lighting and power operating at 100 volts or higher shall be installed in accordance with the requirements of NFPA 70, Article 517. All surface mounted wiring operating at less than 100 volts shall be protected from mechanical injury with metal raceways to a height of seven feet above the floor. Conduits and cables shall be supported in accordance with NFPA 70, Article 300.

(G) Lighting.

(i) Lighting intensity for staff and patient needs shall comply with Chapter 17, Institution and Public Building Lighting, Health Care Facilities, of the Illuminating Engineering Society of North America (IES) Lighting Handbook, published by the IES.

(I) Consideration should be given to controlling intensity and wavelength to prevent harm to the patient's eyes (i.e., cataracts due to ultraviolet light).

(II) Approaches to buildings and parking lots, and all spaces within buildings shall have fixtures that can be illuminated as necessary. All rooms including storerooms, electrical and mechanical equipment rooms, and all attics shall have sufficient artificial lighting so that all parts of these spaces shall be clearly visible.

(III) Consideration should be given to the special needs of the elderly. Excessive contrast in lighting levels that makes effective sight adaptation difficult shall be minimized.

(ii) Means of egress and exit sign lighting intensity shall comply with NFPA 101 §§7-8, 7-9 and 7-10.

(iii) Electric lamps which may be subject to breakage or which are installed in fixtures in confined locations when near woodwork, paper, clothing, or other combustible materials, shall be protected by wire guards, or plastic shields.

(iv) Ceiling mounted examination light fixtures shall be suspended from rigid support structures mounted above the ceiling.

(H) Receptacles. Only listed "hospital" grade single-grounding or duplex-grounding receptacles shall be used in all patient care areas. This does not apply to special purpose receptacles.

(i) Installations of multiple ganged receptacles shall be permitted in patient care areas.

(ii) Electrical outlets powered from the critical branch shall be provided in all patient care, procedure and treatment locations in accordance with NFPA 99 §3-4.2.2.2(c). At least one receptacle at each patient treatment or procedure location shall be powered from the normal power panel.

(iii) Replacement of malfunctioning receptacles and installation of new receptacles powered from the critical branch in existing facilities shall be accomplished with receptacles of the same distinct color as the existing receptacles.

(iv) In locations where mobile X-ray or other equipment requiring special electrical configuration is used, the additional receptacles shall be distinctively marked for the special use.

(v) Each receptacle shall be grounded to the reference grounding point by means of a green insulated copper equipment grounding conductor.

(I) Equipment.

(i) Equipment required for safe operation of the facility shall be powered from the equipment system in accordance with the requirements contained in NFPA 99 §3-4.2.2.3.

(ii) Boiler accessories including feed pumps, heat-circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected and installed to provide both normal and standby service.

(J) Ground fault circuit interrupters (GFCI). GFCIs shall comply with NFPA 70. When GFCIs are used in critical areas, provisions shall be made to ensure that other essential equipment is not affected by activation of one interrupter.

(K) Nurses calling systems. Three different types of nurses calling systems are required to be installed in a facility: a nurses regular calling system; a nurses emergency calling system; and a staff emergency assistance calling system. The facility shall comply with the requirements of this paragraph and any specific requirements for nurses calling systems for the particular unit of the facility in accordance with §510.123 of this subchapter.

(i) A nurses regular calling system is intended for routine communication between each patient and the nursing staff. Activation of the system at a patient's regular calling station will sound a repeating (every 20 seconds) audible signal at the nurse station, indicate type and location of call on the system monitor, and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. The audible signal shall be canceled and two-way voice communication between the patient room and the nursing staff shall be established at the unit's nursing station when the call is answered by the nursing staff. The visible signals in the corridor shall be canceled upon termination of the call. An alarm shall activate at the nurses station when the call cable is unplugged.

(ii) A nurses emergency calling system shall be installed in all toilets used by all patients to summon nursing staff in an emergency. Activation of the system shall sound a repeating (every 5 seconds) audible signal at the nurse station, indicate type and location of call on the system monitor, and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. The visible and audible signals shall be cancelable only at the patient calling station. Activation of the system shall also activate distinct visible signals in the clean workroom, in the soiled workroom, medication, charting, clean linen storage, nourishment, nurse lounge and equipment storage. When conveniently located and accessible from both the bathing and toilet fixtures, one emergency call station may serve one bathroom. A nurses emergency call system shall be accessible to a collapsed patient lying on the floor.

(iii) A staff emergency assistance calling system (code blue) is intended to be used by staff to summon additional help in an emergency. In open suites, an emergency assistant call system device shall be located at the head of each bed and in each individual room. The emergency assistance calling device can be shared between two beds if conveniently located. Activation of the system will sound an audible signal at the nursing unit's nurses station, indicate type and location of call on the system monitor and activate a distinct visible signal in the corridor at the patient suites door. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. Activation of the system shall also activate visible and audible signals in the clean workroom, in the soiled workroom, medication, charting, clean linen storage, nourishment, equipment storage, and examination or treatment rooms with back up to a continuously staffed area (other than the nurse station or an administrative center) from which assistance can be summoned. The system shall have voice communication capabilities so that the type of emergency or help required may be specified.

(L) Emergency electric service. A Type I essential electrical system shall be provided in each facility in accordance with requirements of NFPA 99, NFPA 101, and National Fire Protection Association 110, Standard for Emergency and Standby Power Systems, 1999 edition. Exception: Crisis stabilization units have the option of providing a Type II essential electrical system in accordance with the requirements of NFPA 99 and NFPA 101.

(i) The number of transfer switches to be used shall be based on reliability, design and load considerations.

(ii) All wiring installation of the emergency system of the essential electrical system shall be mechanically protected in nonflexible metal raceways in compliance with NFPA 70 §517-30(c)(3).

(iii) The stored fuel capacity for emergency generators shall be sufficient to permit continuous operation for at least 24 hours at full load.

(M) Fire alarm system. A fire alarm system which complies with NFPA 101 §18-3.4, and with NFPA 72 Chapter 3 requirements, shall be provided in each facility. The required fire alarm system components are as follows.

(i) A fire alarm control panel (FACP) shall be installed at a continuously attended (24 hour) location. A remote fire alarm annunciator listed for fire alarm service and installed at a continuously attended location and is capable of indicating both visual and audible alarm, trouble and supervisory signals in accordance with the requirements of NFPA 72 may be substituted for the FACP.

(ii) Manual fire alarm pull stations shall be installed in accordance with NFPA 101 §18-3.4.

(iii) Smoke detectors for door release service shall be installed on the ceiling at each door opening in the smoke partition in accordance with NFPA 72 §2-10.6, where the doors are held open with electromagnetic devices conforming with NFPA 101 §18-2.2.6.

(iv) Ceiling mounted smoke detectors shall be installed in room containing the FACP when this room is not attended continuously by staff as required by NFPA 72 §1-5.6.

(v) Smoke detectors shall be installed in supply air ducts in accordance with NFPA 72 §2-10.4.2 and §2-10.5, and with NFPA 90A §4-4.2.

(vi) Smoke detectors shall be installed in return air ducts in accordance with requirements of NFPA 72 §2-10.4.2.2 and §2-10.5, and NFPA 90A §4-4.2(2).

(vii) Fire sprinkler system water flow switches shall be installed in accordance with requirements of NFPA 101 §9-6.2; NFPA 13 §3-10; and NFPA 72 §3-8.5.

(viii) Sprinkler system valve supervisory switches shall be installed in accordance with the requirements of NFPA 72 §3-8.6.

(ix) Audible alarm indicating devices shall be installed in accordance with the requirements of NFPA 101, §18-3.4., and NFPA 72 §6-3.

(x) Visual fire alarm indicating devices which comply with the requirements of §510.122(d)(1)(F) of this subchapter (relating to New Construction Requirements) and NFPA 72 §6-4 shall be provided.

(xi) Devices for transmitting alarm for alerting the local fire brigade or municipal fire department of fire or other emergency shall be provided. The devices shall be listed for the fire alarm service by a nationally recognized laboratory and be installed in accordance with such listing and the requirements of NFPA 72.

(xii) A smoke detection system for spaces open to corridor(s) shall be provided when required by NFPA 101 §18-3.6.1.

(xiii) A fire alarm signal notification which complies with NFPA 101 §9-6.3, shall be provided to alert occupants of fire or other emergency.

(xiv) Wiring for fire alarm detection circuits and fire alarm notification circuits shall comply with requirements of NFPA 70, Article 760.

(xv) A smoke detection system for elevator recall shall be located in elevator lobbies, elevator machine rooms and at the top of elevator hoist ways as required by NFPA 72 §3-9.3.7.

(I) The elevator recall smoke detection system in new construction shall comply with requirements of American Society of Mechanical Engineers/American National Standards Institute (ASME/ANSI) A17.1, Safety Code for Elevators and Escalators, 1996 edition.

(II) The elevator recall smoke detection system in existing facilities shall comply with requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators, 1995 edition.

(xvi) A smoke detection system for initiating smoke removal from atriums shall be located above the highest floor level of the atrium and at return intakes from the atrium in accordance with National Fire Protection Association 92B, Guide for Smoke Management Systems in Malls, Atria, and Large Areas, 1995 edition.

(xvii) Smoke detectors for shut-down of air handling units shall be provided. The detectors shall be installed in accordance with NFPA 90A §4-4.2.

(xviii) New or modified fire alarm systems shall be certified as meeting applicable NFPA standards such as NFPA 101, 72A, 72E, etc. on form FML-009 040392 of the Office of the State Fire Marshal. A copy of the fire alarm system certification shall be submitted to HHSC.

(N) Telecommunications and information systems. Telecommunications and information systems central equipment shall be installed in a separate location designed for the intended purpose. Special air conditioning and voltage regulation shall be provided as recommended by the manufacturer.

(O) Lightning protection systems. When installed, lightning protection systems shall comply with National Fire Protection Association 780, Standard for the Installation of Lightning Protection Systems, 1997 edition.

§510.123. Spatial Requirements for New Construction.

(a) Administration and public suite. The following rooms or areas shall be provided.

(1) Primary entrance. An entrance at grade level shall be accessible and protected from inclement weather with a drive-under canopy for loading and unloading passengers.

(2) Lobby. A main lobby shall be located at the primary entrance and shall include a reception and information counter or desk, waiting spaces, public toilet facilities, public telephones, drinking fountains, and storage room or alcove for wheelchairs.

(3) Admissions area. An admissions area shall include a waiting area, work counters or desk, private interview spaces, and storage room or alcove for wheelchairs. The waiting area and wheelchair storage may be shared with similar areas located in the main lobby.

(4) General or individual offices. Office space shall be provided for business transactions, medical and financial records, and administrative and professional staffs.

(5) Multipurpose rooms. Rooms shall be provided for conferences, meetings, and health education purposes including provisions for showing visual aids.

(6) Storage. Storage for office equipment and supplies shall be provided. The construction protection for the storage room or area shall be in accordance with the National Fire Protection Association 101, Code for Safety to Life from Fire in Buildings and Structures, 1997 edition (NFPA 101) §18-3.1.

(b) Cart cleaning and sanitizing unit. A cart cleaning and sanitizing unit is optional for crisis stabilization units.

(1) Architectural requirements.

(A) Cart cleaning, sanitizing and storage shall be provided for carts serving dietary services and linen services.

(B) Cart facilities may be provided for each service or be centrally located.

(C) Hand washing fixtures shall be provided in cart cleaning, sanitizing and storage areas.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter (relating to New Construction Requirements) and this paragraph.

(A) Flooring in the cart cleaning and sanitizing unit shall be of the seamless type, or ceramic or quarry tile as required by §510.122(d)(2)(B)(iii)(III) or (IV) of this subchapter.

(B) Ceilings in the cart cleaning and sanitizing unit shall be the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Hand washing fixtures shall be provided with hot and cold water. Hot and cold water fixtures shall be provided in cart cleaning and sanitizing locations.

(B) Where floor drains or floor sinks are installed, they shall be of a type that can be easily cleaned by removal of the cover. Removable stainless steel mesh shall be provided in addition to a grilled drain cover to prevent entry of large particles of waste which might cause stoppages. Floor drains and floor sinks shall be located to avoid conditions where removal of covers for cleaning is difficult.

(c) Central sterile supply suite. A central sterile supply suite is optional for crisis stabilization units.

(1) Architectural requirements.

(A) Supply storage. A storage room for clean and sterile supplies shall be provided. The storage room shall have adequate areas and counters for breakdown of prepackaged supplies.

(B) Equipment storage. An equipment storage room shall be provided.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph. Ceilings in supply storage room shall be monolithic type in accordance with §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) The sterile supply room shall include provisions for ventilation, humidity, and temperature control.

(B) Filtration requirements for air handling units serving the central sterile supply suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter (relating to Tables).

(C) Duct linings exposed to air movement shall not be used in ducts serving the central sterile supply suite unless terminal filters of at least 90% efficiency are installed downstream of linings. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(d) Dietary suite.

(1) Architectural requirements.

(A) General. Construction, equipment, and installation shall comply with the standards specified in 25 TAC Chapter 228 (relating to Retail Food Establishments).

(B) Food service facilities. Food services shall be provided by an on-site food preparation system or an off-site food service system or a combination of the two. The following minimum functional elements shall be provided on-site regardless of the type of dietary services.

(i) Dining area. Provide dining space for ambulatory patients, staff, and visitors with a minimum floor space of 15 square feet per person to be seated. The footage requirement does not include serving areas. The dining area and service areas shall be separate from the food preparation and distribution areas.

(ii) Receiving area. This receiving area shall have direct access to the outside for incoming dietary supplies or off-site food preparation service and shall be separate from the general receiving area. The receiving area shall contain a control station and an area for breakout for loading, unloading, uncrating, and weighing supplies. The entrance area to the receiving area shall be covered from the weather.

(iii) Storage spaces. Storage spaces shall be convenient to receiving area and food preparation area and shall be located to exclude traffic through the food preparation area. Regardless of the type of food services provided, the facility shall provide storage of food for emergency use for a minimum of four calendar days.

(I) Storage space. Storage space shall be provided for bulk, refrigerated, and frozen foods.

(II) Cleaning supply storage. This room or closet shall be used to store non-food items that might contaminate edibles. This storage area may be combined with the housekeeping room.

(iv) Food preparation area. Counter space shall be provided for food prep work, equipment, and an area to assemble trays for distribution for patient meals.

(v) Ice making equipment. Ice making equipment shall be provided for both drinks and food products (self-dispensing equipment) and for general use (storage-bin type equipment).

(vi) Hand washing. Hand washing fixtures with hands-free operable controls shall be conveniently located at all food preparation areas and serving areas.

(vii) Food service carts. When a cart distribution system is provided, space shall be provided for storage, loading, distribution, receiving, and sanitizing of the food service carts. The cart traffic shall be designed to eliminate any danger of cross-circulation between outgoing food carts and incoming soiled carts, and the cleaning and sanitizing process. Cart circulation shall not be through food processing areas.

(viii) Ware washing room. A ware washing room equipped with commercial type dishwasher equipment shall be located separate from the food preparation and serving areas. Space shall be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. Hand washing facilities with hands-free operable controls shall be located within the soiled dish wash area. A physical separation to prevent cross traffic between the dirty side and clean side of the dish wash areas shall be provided.

(ix) Pot washing facilities. A three compartmented sink of adequate size for intended use shall be provided convenient to the food preparation area. Supplemental heat for hot water to clean pots and pans shall be by booster heater or by steam jet.

(x) Waste storage room. A food waste storage room shall be conveniently located to the food preparation and ware washing areas but not within the food preparation area. It shall have direct access to the facility's waste collection and disposal facilities. A waste storage room is optional for crisis stabilization units.

(xi) Sanitizing facilities. Storage areas and sanitizing facilities for garbage or refuse cans, carts, and mobile tray conveyors shall be provided. All containers for trash storage shall have tight-fitting lids.

(xii) Housekeeping room. A housekeeping room shall be provided for the exclusive use of the dietary department. Where hot water or steam is used for general cleaning, additional space within the room shall be provided for the storage of hoses and nozzles.

(xiii) Office spaces. An office shall be provided for the use of the food service manager or the dietary service manager. In smaller facilities, a designated alcove may be located in an area that is part of the food preparation area.

(xiv) Toilets and locker spaces. A toilet room shall be provided for the exclusive use of the dietary staff. Toilets shall not open directly into the food preparation areas but must be in close proximity to them. For larger facilities, a locker room or space for lockers shall be provided for staff belongings.

(C) Additional service areas, rooms, and facilities. When an on-site food preparation system is used, in addition to the items required in subparagraph (B), the following service areas, rooms, and facilities shall be provided.

(i) Food preparation facilities. When food preparation systems are provided, there shall be space and equipment for preparing, cooking, and baking.

(ii) Tray assembly line. A patient tray assembly and distribution area shall be located within close proximity to the food preparation and distribution areas.

(iii) Food storage. The food storage room shall be adequate in size to accommodate food for a seven calendar day menu cycle.

(iv) Additional storage areas. Additional areas shall be provided for the storage of cooking wares, extra trays, flatware, plastic and paper products, and portable equipment.

(v) Drying storage area. Provisions shall be made for drying and storage of pots and pans from the pot washing room.

(D) Equipment. Equipment for use in the dietary suite shall meet the following requirements.

(i) Mechanical devices shall be heavy duty, suitable for the use intended, and easily cleaned. Where equipment is movable, provide heavy duty locking casters. Equipment with fixed utility connections shall not be equipped with casters.

(ii) Floor, wall, and top panels of walk-in coolers, refrigerators, and freezers shall be insulated. Coolers and refrigera-

tors shall be capable of maintaining a temperature down to freezing. Freezers shall be capable of maintaining a temperature of 20 degrees below 0 degrees Fahrenheit. Coolers, refrigerators, and freezers shall be thermostatically controlled to maintain desired temperature settings in increments of two degrees or less. Interior temperatures shall be indicated digitally and visible from the exterior. Controls shall include audible and visible high and low temperature alarm. The time of alarm shall be automatically recorded.

(iii) Walk-in units may be lockable from the outside but must have a release mechanism for exit from inside at all times. The interior shall be lighted. All shelving shall be corrosion resistant, easily cleaned, and constructed and anchored to support a loading of at least 100 pounds per linear foot.

(iv) All cooking equipment shall be equipped with automatic shut-off devices to prevent excessive heat buildup.

(E) Vending services. When vending machines are provided, a dedicated room or an alcove shall be located so that access is available at all times.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Details.

(i) Food storage shelves shall not be less than six inches above the finished floor and the space below the bottom shelf shall be closed in and sealed tight for ease of cleaning.

(ii) Operable windows and doors not equipped with automatic closing devices shall be equipped with insect screens.

(iii) Food processing areas in the central dietary kitchen shall have ceiling heights not less than nine feet. Ceiling mounted equipment shall be supported from rigid structures located above the finished ceiling.

(iv) Mirrors shall not be installed at hand washing fixtures in the food preparation areas.

(B) Finishes.

(i) Floors in areas used for food preparation, food assembly, soiled and clean ware cleaning shall be water-resistant and grease-proof. Floor surfaces, including tile joints, shall be resistant to food acids.

(ii) Wall bases in food preparation, food assembly, soiled and clean ware cleaning and other areas which are frequently subject to wet cleaning methods shall be made integral and coved with the floor, tightly sealed to the wall, constructed without voids that can harbor insects, retain dirt particles, and be impervious to water.

(iii) In the dietary and food preparation areas, the wall construction, finishes, and trim, including the joints between the walls and the floors, shall be free of voids, cracks, and crevices.

(iv) The ceiling in food preparation and food assembly areas shall be washable as required by §510.122(d)(2)(B)(vi)(II) of this subchapter.

(v) The ceiling in the food storage room and soiled and clean ware cleaning area shall be of the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) Exhaust hoods handling grease-laden vapors in food preparation centers shall comply with National Fire Protection Association 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 edition. All hoods over cooking ranges shall be equipped with grease filters, fire extinguishing systems, and heat-actuated fan controls. Clean out openings shall be provided every 20 feet and at any changes in direction in the horizontal exhaust duct systems serving these hoods. (Horizontal runs of ducts serving range hoods should be kept to a minimum.)

(B) When air change standards in Table 3 of §510.131(c) of this subchapter do not provide sufficient air for proper operation of exhaust hoods (when in use), supplementary filtered makeup air shall be provided in these rooms to maintain the required airflow direction and exhaust velocity. Makeup systems for hoods shall be arranged to minimize "short circuiting" of air and to avoid reduction in air velocity at the point of contaminant capture.

(C) Air handling units serving the dietary suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) The kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas. Grease traps shall be of capacity required and shall be accessible from outside of the building without need to interrupt any services.

(B) Grease traps or grease interceptors shall be located outside the food preparation area and shall comply with the requirements in the International Association of Plumbing and Mechanical Officials National Standard Plumbing Code, 2000 edition.

(C) The material used for plumbing fixtures shall be non-absorptive and acid-resistant.

(D) Water spouts used at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and containers.

(E) Hand washing fixtures used by food handlers shall be trimmed with valves that can be operated without hands. Single lever or wrist blade devices may be used. Blade handles used for this purpose shall not be less than four inches in length.

(F) Drainage and waste piping shall not be installed in the space above the ceiling or installed in an exposed location in food preparation centers, food serving facilities and food storage areas unless special precautions are taken to protect the space below from leakage and condensation from necessary overhead piping.

(G) No plumbing lines may be exposed overhead or on walls where possible leaks would create a potential for food contamination.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Exhaust hoods shall have an indicator light indicating that the exhaust fan is in operation.

(B) The electrical circuits to equipment in wet areas shall be provided with five milliampere GFCI.

(e) Emergency treatment room.

(1) Architectural requirements.

(A) Emergency treatment room. As a minimum requirement, a facility shall provide at least one emergency treatment

room to handle emergencies. The emergency treatment room may be located anywhere in the facility and shall meet the following requirements.

(i) The emergency treatment room shall have a minimum clear area of 120 square feet clear floor area exclusive of fixed and movable cabinets and shelves. The minimum clear room dimension exclusive of fixed cabinets and built-in shelves shall be 10 feet. The emergency treatment room shall contain cabinets, medication storage, work counter, examination light, and hand washing fixtures with hands-free operable controls. Exception: Crisis stabilization units are not required to have medication storage in the emergency treatment room.

(ii) Storage space shall be provided within the room or on an emergency cart and be under staff control for general medical emergency supplies and medications. Adequate space shall be provided for emergency equipment.

(B) Secured holding room. When provided, this room shall be constructed to allow for security, patient and staff safety, patient observation, and sound proofing.

(C) Service areas. The following service areas shall be provided.

(i) Soiled workroom. The workroom shall contain a work counter, a clinical sink or equivalent flushing type fixture, hand washing fixture with hands-free operable controls, waste receptacles, and soiled linen receptacles. The soiled workroom in the nursing suite may be shared with the emergency treatment room if it is located conveniently nearby.

(ii) Housekeeping room. The housekeeping room shall be located nearby.

(iii) Patient toilet. A toilet room shall be provided and located nearby.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Flooring used in the treatment room, secure holding area, and soiled workroom shall be of the seamless type as required by §510.122(d)(2)(B)(iii)(III) of this subchapter.

(B) Ceilings in soiled workrooms and secure holding rooms shall be of the monolithic type as required by §510.122(d)(2)(B)(vi)(III) of this subchapter.

(3) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph. Duct linings exposed to air movement shall not be used in ducts serving any treatment rooms and secure holding rooms. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter. When provided, medical gas systems shall be in accordance with §510.122(d)(4)(A)(iii) of this subchapter.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) General.

(i) Each treatment room shall have a minimum of six duplex electrical receptacles. Two duplex electrical receptacles shall be located convenient to the head of the bed.

(ii) Each work counter and table shall have access to two duplex receptacles connected to the critical branch of the emergency electrical system and be labeled with panel and circuit number.

(B) Nurses calling systems. A nurses regular calling system shall be provided for the treatment room in accordance with §510.122(d)(5)(K)(i) of this subchapter.

(f) Employees suite. Lockers, lounges, toilets, and other amenities as determined by the facility shall be provided throughout the facility for employees and volunteers. These amenities are in addition to, and separate from, those required for the medical staff and the public.

(g) Engineering suite and equipment areas.

(1) General. The following areas or rooms shall be provided:

(A) an engineer's office with file space and provisions for protected storage of facility drawings, records, manuals, etc.;

(B) a general maintenance shop for repair and maintenance;

(C) a separate room for building maintenance supplies and equipment and storage of bulk solvents and flammable liquids shall be in a separate building and not within the facility building;

(D) a medical equipment room which includes provisions for the storage, repair, and testing of electronic and other medical equipment;

(E) a separate room or building for yard maintenance equipment and supplies. When a separate room is within the physical plant the room shall be located so that equipment may be moved directly to the exterior. Yard equipment or vehicles using flammable liquid fuels shall not be stored or housed within the facility building; and

(F) sufficient space in all mechanical and electrical equipment rooms for proper maintenance of equipment. Provisions shall also be made for removal and replacement of equipment.

(2) Additional areas or rooms. Additional areas or rooms for mechanical, and electrical equipment shall be provided within the physical plant or installed in separate buildings or weatherproof enclosures with the following exceptions.

(A) An area shall be provided for cooling towers and heat rejection equipment when such equipment is used.

(B) An area for the medical gas park and equipment shall be provided. For smaller medical gas systems, the equipment may be housed in a room within the physical plant in accordance with National Fire Protection Association 99, Standard for Health Care Facilities, 1999 edition (NFPA 99), Chapters 4 and 8.

(C) When provided, compactors, dumpsters, and incinerators shall be located in an area remote from public entrances.

(h) General stores.

(1) General. In addition to storage rooms in individual departments, a central storage room shall also be provided. General stores may be located in a separate building on-site with provisions for protection against inclement weather during transfer of supplies.

(2) Receiving. Central storage areas shall be provided with an off-street unloading and receiving area protected from inclement weather.

(3) General storage room. General storage room with a total area of not less than 12 square feet per inpatient bed shall be provided. The storage room may be within the facility, or separate building on-site. A portion of the storage may be provided off-site.

(4) Outpatient suite storage room. A storage room for the outpatient services shall be provided at least equal to five percent of the total area of the outpatient suite. This required storage room area may be combined with general stores.

(i) Geriatric, Alzheimer, and other dementia nursing suites. When geriatric, Alzheimer, or other dementia nursing suites are provided, the nursing suite shall comply with the requirements in subsection (o) of this section with the following exceptions.

(1) A patient bedroom suite shall be 120 square feet in a single patient bedroom suite and 200 square feet in multiple-bed room suites.

(2) Each patient bedroom shall have storage for extra blankets, pillows, and linen.

(3) Patient bedroom doors shall be a minimum of three feet eight inches in width.

(4) Patients shall have access to at least one bathtub in each nursing suite.

(5) A minimum of two separate social spaces, one appropriate for noisy activities and the other for quiet activities, shall be provided. The combined total area shall be not less than 30 square feet per bed space with not less than 140 square feet for each of the two spaces, whichever is greater. This space may be shared with the dining area or room.

(6) Storage space for wheelchairs shall be provided in the nursing unit.

(j) Imaging suite.

(1) Architectural requirements.

(A) General. When diagnostic imaging services are provided, the minimum the facility shall provide is a diagnostic radiographic (X-ray) room.

(i) Diagnostic radiographic (x-ray) room sizes shall be in compliance with manufacturer's recommendation. When portable x-ray equipment is used, the portable unit shall be stored in a secured room.

(ii) When radiation protection is required for any diagnostic imaging room, a medical physicist licensed under Texas Occupations Code Chapter 602, shall specify the type, location, and amount of radiation protection to be installed for the layout and equipment selections.

(iii) Each X-ray room shall include a shielded control alcove. The control alcove shall be provided with a view window designed to permit full view of the examination table and the patient at all times.

(iv) Warning signs capable of indicating that the equipment is in use shall be provided.

(B) Service areas. The following service areas shall be provided.

(i) Patient waiting area. The area shall be out of traffic and under direct staff visual control.

(ii) Patient toilet rooms. Toilet rooms with hand washing amenities shall be located convenient to the waiting area.

(iii) Patient dressing rooms. Dressing rooms shall be convenient to the waiting areas and X-ray rooms.

(iv) Hand washing facilities. A freestanding hand washing fixture with hands-free controls shall be provided in or near the entrance to each diagnostic and procedure room unless noted otherwise. Hand washing facilities shall be arranged to minimize any incidental splatter on nearby personnel or equipment.

(v) Contrast media preparation. This room shall include a work counter, a sink with hands-free operable controls, and storage. One preparation room may serve any number of rooms. When prepared media is used, this area may be omitted, but storage shall be provided for the media.

(vi) Film processing room. A darkroom shall be provided for processing film unless the processing equipment normally used does not require a darkroom for loading and transfer. When daylight processing is used, the darkroom may be minimal for emergency and special uses. Film processing shall be located convenient to the procedure rooms and to the quality control area.

(vii) Quality control area or room. An area or room for film viewing shall be located near the film processor. All view boxes shall be illuminated to provide light of the same color value and intensity.

(viii) Film storage (active). A room shall include a cabinet or shelves for filing patient film for immediate retrieval.

(ix) Film storage (inactive). A room for inactive film storage shall be provided. It may be outside the imaging suite but must be under the administrative control of imaging suite personnel and be properly secured to protect films against loss or damage.

(x) Storage for unexposed film. Storage amenities for unexposed film shall include protection of film against exposure or damage.

(xi) Storage of cellulose nitrate film. When used, cellulose nitrate film shall be stored in accordance with the requirements of National Fire Protection Association 40, Standard for the Storage and Handling of Cellulose Nitrate Motion Picture Film, 1994 edition.

(xii) Housekeeping room. The room may serve multiple departments when conveniently located.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter and this paragraph.

(A) Details.

(i) Radiation protection shall be designed, tested, and approved by a medical physicist licensed under Texas Occupations Code Chapter 602.

(ii) The design and environmental controls associated with licensable quantities of radioactive material in laboratories, imaging rooms, or both shall be approved by the Texas Department of State Health Services Radiation Control Program prior to licensed authorizations.

(iii) Where protected alcoves with view windows are required, provide a minimum of 1 foot 6 inches between the view window edge or frame and the outside partition edge.

(iv) Imaging procedure rooms shall have ceiling heights not less than nine feet. Ceilings containing ceiling-mounted equipment shall be of sufficient height to accommodate the equipment of fixtures and their normal movement.

(B) Finishes.

(i) Flooring used in contrast media preparation and soiled workroom shall be of the seamless type as required by §510.122(d)(2)(B)(iii)(III) of this subchapter.

(ii) A lay-in type ceiling is acceptable for the diagnostic room.

(3) Mechanical Requirements.

(A) Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(B) Air handling units serving the imaging suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph. When automatic film processors are used, a receptacle of adequate size with hot and cold water for cleaning the processor racks shall be provided.

(5) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) General.

(i) Each imaging procedure room shall have at least four duplex electrical receptacles.

(ii) A special grounding system in areas such as imaging procedures rooms where a patient may be treated with an internal probe or catheter shall comply with Chapter 9 of NFPA 99 and Article 517 of NFPA 70.

(iii) General lighting with at least one light fixture powered from a normal circuit shall be provided in imaging procedures rooms in addition to special lighting units at the procedure or diagnostic tables.

(B) Nurses calling system.

(i) Nurses regular calling system. The nurses regular calling system shall be provided for patient dressing rooms in accordance with §510.122(d)(5)(K)(i) of this subchapter.

(ii) Nurses emergency calling system. In toilet rooms used by inpatients and outpatients, a nurses emergency call station shall be provided in accordance with §510.122(d)(5)(K)(ii) of this subchapter.

(iii) Staff emergency assistance calling system. A staff emergency assistance calling system (code blue) shall be provided for staff to summon additional assistance for each imaging procedure room in accordance with §510.122(d)(5)(K)(iii) of this subchapter.

(k) Laboratory suite.

(1) Architectural requirements.

(A) General. The required laboratory testing shall be performed on-site or provided through a contractual arrangement with a laboratory service.

(i) Provisions for laboratory services shall be provided within the facility for urinalysis, blood glucose and electrolytes.

(ii) Each laboratory unit shall meet the requirements of Chapter 10 of NFPA 99 and Chapter 18 of NFPA 101.

(B) Minimum laboratory. When laboratory services are provided off-site by contract, the following minimum areas or rooms shall be provided within the facility.

(i) Laboratory work room. The laboratory workroom shall include a counter and a sink with hands-free operable controls.

(ii) General storage. Cabinets or closets shall be provided for supplies and equipment used in obtaining samples for testing. A refrigerator or other similar equipment shall be provided for specimen storage waiting for transfer to off-site testing.

(iii) Specimen collection room. A blood collection room shall be provided with a counter, space for seating, and hand washing fixture with hands-free operable controls. A toilet and lavatory with hands-free operable controls shall be provided for specimen collection. This room may be outside the laboratory suite if conveniently located.

(C) On-site laboratory. When the facility provides on-site laboratory services, the following areas or rooms shall be provided in addition to the requirements in paragraph (1)(A) and (1)(B) of this subsection.

(i) Laboratory workrooms. The laboratory work room shall include counters, space appropriately designed for laboratory equipment, sinks with hands-free operable controls, vacuum, gases, air, and electrical services as needed.

(ii) General storage. Storage, including refrigeration for reagents, standards, supplies, and stained specimen microscope slides, etc. shall be provided. Separate spaces shall be provided for such incompatible materials as acids and bases, and vented storage shall be provided for volatile solvents.

(iii) Chemical safety. When chemical safety is a requirement, provisions shall be made for an emergency shower and eye flushing devices.

(iv) Flammable liquids. When flammable or combustible liquids are used, the liquids shall be stored in approved containers, in accordance with National Fire Protection Association 30, Flammable and Combustible Liquids Code, 1996 edition.

(v) Radioactive materials. When radioactive materials are employed, storage amenities shall be provided.

(D) Service areas or rooms. The following service areas or rooms shall be provided.

(i) Hand washing amenities. Each laboratory room or work area shall be provided with a hand washing fixture with hands-free operable controls.

(ii) Office spaces. The scope of laboratory services shall determine the size and quantity for administrative areas including offices as well as space for clerical work, filing, and record maintenance. At a minimum, an office space shall be provided for the use of the laboratory service director.

(iii) Staff facilities. Lounge, locker, and toilet amenities shall be conveniently located for male and female laboratory staff. These may be outside the laboratory area and shared with other departments.

(iv) Housekeeping room. A housekeeping room shall be located nearby.

(2) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this subchapter. Floors in laboratories

shall comply with the requirements of §510.122(d)(2)(B)(iii) of this subchapter except that carpet flooring shall not be used.

(3) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) No air from the laboratory areas shall be recirculated to other parts of the facility. Recirculation of air within the laboratory suite is allowed.

(B) When laboratory hoods are provided, they shall meet the following general requirements.

(i) The average face velocity of each exhaust hood shall be at least 75 feet per minute.

(ii) The exhaust shall be connected to an exhaust system to the outside which is separate from the building exhaust system.

(iii) The exhaust fan shall be located at the discharge end of the system.

(iv) The exhaust duct system shall be of noncombustible and corrosion resistant material.

(C) Filtration requirements for air handling units serving the laboratory suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(D) Duct linings exposed to air movement shall not be used in ducts serving any laboratory room and clean room unless terminal filters of at least 80% efficiency are installed downstream of linings. This requirement shall not apply to mixing boxes and acoustical traps that have special coverings over such lining.

(4) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) General.

(i) Faucet spouts at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and the contents of beakers, test tubes, etc.

(ii) Drain lines from sinks used for acid waste disposal shall be made of acid-resistant material.

(iii) Drain lines serving some types of automatic blood-cell counters must be of carefully selected material that will eliminate potential for undesirable chemical reactions (or explosions) between sodium azide wastes and copper, lead, brass, and solder, etc.

(B) Medical gas systems. When provided, medical gas systems shall comply with §510.122(d)(4)(A)(iii) of this subchapter. The number of outlets in the laboratory for vacuum, gases, and air shall be determined by the functional program requirements.

(l) Laundry suite. Laundry amenities may be provided on-site or off-site. On-site laundry services may be within the facility or in a separate building.

(1) Architectural requirements.

(A) General. The following amenities are required for both on-site or off-site commercial laundry services.

(i) The laundry room shall be equipped and ventilated so as to minimize the dissemination of contaminants.

(ii) Soiled and clean linen processing areas shall be physically separated.

(iii) An adequate amount of hand washing fixtures shall be provided in both the soiled and clean processing areas.

(B) On-site laundry processing. When linen is processed within the facility or in a separate building located on-site, the following minimum requirements shall be provided.

(i) A receiving, holding, and sorting room for control and distribution of soiled linen shall be provided. This area may be combined with the soiled linens processing room. Discharge from soiled linen chutes may be received within this room or in a separate dedicated room.

(ii) A laundry processing room shall be provided which shall contain commercial type equipment capable of processing at least a seven-day laundry supply within the regular scheduled work week.

(iii) A clean linen processing room shall be provided and shall include built-in dryers and folding counters or tables. This area shall have provisions for inspections, folding, packing, and mending of linen.

(iv) A holding room or area for storage and issuing of clean linen shall be provided but may be combined with clean linen processing room.

(C) Off-site laundry processing. When linen is processed off the facility site, the following minimum requirements shall be provided on-site:

(i) a service entrance which shall have protection from inclement weather, for loading and unloading of linen;

(ii) control station for pickup and receiving;

(iii) soiled linen holding room;

(iv) a central clean linen storage room and issuing room in addition to linen storage required at the individual patient suites. This central holding area shall include provisions for inspecting, sorting, and mending; and

(v) cart storage areas, which shall be located out of pedestrian traffic and shall be provided separately for clean and soiled linen.

(D) Service areas for on-site laundry processing. The laundry shall be separated from patient rooms, areas of food preparation and storage, and areas in which clean supplies and equipment are stored. An on-site laundry shall have the following services areas and facilities.

(i) Office space. Office space for director of laundry services.

(ii) Equipment layout for soiled and clean linen. The laundry equipment processing shall be arranged to permit an orderly work flow and minimize cross-traffic that might mix clean and soiled operations.

(iii) Storage. Storage space and cabinets for soaps, stain removers, and other laundry processing agents shall be located in the soiled and clean processing rooms.

(iv) Cart sanitizing. Cart sanitizing shall comply with subsection (b) of this section.

(v) Staff toilets. Toilets may be outside the unit but shall be convenient for staff use and shall contain hand washing fixtures with hands-free operable controls.

(vi) Staff lockers. Lockers may be in laundry suite or part of a central locker area when convenient to the laundry.

(vii) Housekeeping room.

(2) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this chapter and this paragraph.

(A) The ventilation system shall include adequate intake, filtration, exchange rate, and exhaust in accordance with Table 3 and Table 4 of §510.131(c) and (d) of this subchapter.

(B) Filtration requirements for air handling units serving the laundry suite shall be equipped with filters having efficiencies equal to, or greater than specified in Table 4 of §510.131(d) of this subchapter.

(C) Direction of air flow of the HVAC systems shall be from clean to soiled areas.

(D) The ventilation system for soiled processing area shall have negative air pressure while the clean processing area shall have positive pressure.

(m) Medical records suite. The following rooms, areas, or offices shall be provided in the medical records suite:

(1) medical records administrator or technician office;

(2) review and dictating rooms or spaces;

(3) work area which includes provisions for sorting, recording, or microfilming records; and

(4) file storage room. Rooms containing open file systems or moveable filing storage systems shall be considered as hazardous. The construction protection for the storage room or area shall comply with NFPA 101 §18-3.2.

(n) Nursing suite. The nursing suite shall be designed to facilitate care of ambulatory and non-ambulatory inpatients.

(1) Physical environment. A nursing suite shall provide a safe environment for patients and staff.

(A) The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views and with the organization of various functions accessible to common spaces while not jeopardizing desirable levels of patient privacy.

(B) Interior finishes, lighting, and furnishings shall present an atmosphere which is as noninstitutional as possible, consistent with applicable fire safety requirements. Security and safety devices should not be present in a manner to attract or challenge tampering by patients.

(2) Architectural requirements. Architectural requirements shall be in accordance with §510.122(d)(1) of this subchapter and this paragraph.

(A) Handicapped accessibility requirements. At least 10 percent of patient room suites, bathing units and toilets, and all public and common use areas shall be designed and constructed to be handicapped accessible. These requirements shall apply in all new construction and when an existing nursing suite or a portion thereof is converted from one service to another.

(B) Patient room suites. A patient room suite shall consist of the patient room and a toilet room or bathroom. Patient room suites shall comply with the following requirements.

(i) Maximum patient room capacity. The maximum patient room capacity shall be two patients. In existing facilities where renovation work is undertaken and the present capacity is more than two patients, the maximum room capacity shall be no more than the present capacity with a maximum of four patients.

(ii) Single-bed patient room. In a single-bed patient room, the minimum clear floor area shall be 100 square feet. The minimum clear floor area in an accessible private patient room shall be 120 square feet. The minimum room dimension shall be not less than 10 feet.

(iii) Multi-bed patient room. In a multi-bed patient room, the minimum clear floor area shall be 80 square feet per bed. Minimum clear floor space in an accessible multi-bed room shall be 110 square feet per bed. Design of multi-bed patient rooms shall not restrict independent patient access to the corridor, lavatory, or bathroom.

(iv) Arrangement of patient rooms. Minor encroachments including columns and wall hung lavatories that do not interfere with functions may be ignored when determining space requirements for patient rooms.

(I) Required clear floor space in patient rooms shall be exclusive of toilet rooms, closets, lockers, built-in cabinets, wardrobes, alcoves, or vestibules.

(II) A clearance of 3 feet 8 inches shall be available at the foot of each bed in multi-bed patient rooms to permit the passage of equipment and beds. A minimum distance of three feet between a wall and the side of a bed and four feet between beds shall be provided. A minimum distance of five feet between a wall and the side of a bed and four feet between beds shall be provided in an accessible semi-private room or one intended for rehabilitation patients. Arrangement of beds shall be such that sufficient space is provided for a bed and maneuvering space for a wheelchair.

(III) Sleeping areas shall have doors for privacy. Design for visual privacy in multi-bed rooms shall not restrict patient access to the room, toilet, or observation by staff.

(v) Patient bathroom. Each patient shall have access to a bathroom without having to enter the general corridor area. Each bathroom shall contain a toilet, hand washing fixtures, and storage shelf or cabinet and serve not more than four patient beds or two patient rooms. Hand washing fixtures may be located in the patient room.

(vi) Bathing rooms. One bathtub or shower shall be provided for each four patient beds or space which is not otherwise served by bathing rooms within patients' rooms. Each tub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing.

(vii) Patient storage. Each patient shall have a separate wardrobe, locker, or closet that is suitable for hanging full-length garments and for storing personal effects. A minimum of 12 lineal inches of hanging space shall be provided per patient.

(C) Security rooms. When security rooms are provided by the treatment program narrative, the security rooms shall be single patient suite rooms designed to minimize potential for escape, hiding, injury to self or others, or suicide. Access to toilets, showers, and wardrobes shall be restricted. The patient room suite shall be in accordance with subparagraph (B)(ii) of this paragraph. Security rooms may be centralized on one unit or decentralized among units.

(D) Seclusion suite. There shall be a seclusion suite in each nursing suite intended for short-term occupancy by a single person requiring security and protection from self or others. The seclusion suite shall consist of seclusion rooms, an anteroom or a vestibule, a toilet, and hand washing fixtures.

(i) Each seclusion room shall be located and designed in a manner affording direct visual supervision by nursing staff and shall be constructed to prevent patient hiding, escape, injury, or suicide. There shall be a minimum of one seclusion room for each 24 beds or any portion thereof.

(I) The floor area of each seclusion room shall be not less than 60 square feet. The minimum room dimension shall be six feet.

(II) The seclusion room shall have a minimum ceiling height of nine feet.

(III) The door to each seclusion room shall have no hardware on the room side and shall open out. A vision panel shall be provided in each door to permit staff observation of the entire room while maintaining privacy from the public and other patients. The seclusion room door shall swing out.

(IV) Each seclusion room shall have natural light (skylight or window) in order to maintain a therapeutic environment. Skylight wells or windows shall be not less than 400 square inches in area.

(ii) Access to the seclusion room from any public space such as a corridor shall be through an anteroom. When the seclusion suite is directly accessible from the nurse station, a vestibule may be provided in place of an anteroom. A cased opening to the vestibule in lieu of a door may be provided as long as the arrangement assures privacy from the public and other patients.

(I) The minimum dimension of the anteroom or vestibule shall be eight feet.

(II) The door to the anteroom shall swing in.

(iii) There shall be at least one toilet room directly accessible from the anteroom or vestibule.

(I) The toilet room shall be large enough to safely manage the patient.

(II) The toilet room door shall swing out into the anteroom or vestibule.

(III) A water closet and hand washing fixtures shall be provided in the toilet room. An unbreakable wall hung mirror may be provided.

(IV) Doors for the seclusion room and anteroom shall be not less than 3 feet 8 inches in width.

(V) When the interior of the seclusion room is padded, the padding shall be a Class "A." The flame spread rating shall be 0-25 and the smoke development rating shall be 0-450 in accordance with NFPA 101 Chapter 8.

(E) Airborne infection isolation suites. When an isolation suite is provided, the suite may be located within a nursing suite or in a separate isolation unit. Each airborne infection isolation suite shall consist of a work area, a patient room, and a patient bathroom.

(i) The work area may be a separately enclosed anteroom or a vestibule that is open to and is located immediately inside the door to the patient room. It shall have amenities for hand washing, gowning, and storage of clean and soiled materials. One enclosed anteroom may serve multiple isolation rooms.

(ii) Each patient room shall have a clear floor area of 120 square feet exclusive of the work area and shall contain only one bed.

(iii) Each bathroom shall be designed for the use of the handicapped and shall contain bathing fixtures, toilet fixtures and hand washing fixtures. Each bathroom shall be arranged to provide access from the patient room without entering or passing through the work area.

(iv) At least one airborne infection isolation suite with an enclosed anteroom shall be provided.

(v) Ventilation requirements for the isolation rooms shall be in accordance with Table 3 of §510.131(c) of this subchapter.

(vi) Doors to airborne infection isolation rooms shall be provided with self-closing devices.

(F) Social spaces. A minimum of two separate social spaces, one appropriate for noisy activities and the other for quiet activities, shall be provided. The combined total area shall be not less than 40 square feet per bed space with not less than 160 square feet for each of the two spaces, whichever is greater. This space may be shared with the dining area or room.

(G) Group therapy room. A room for group therapy shall be included. The room shall not be less than 250 square feet. The group therapy room may be combined with the quiet space required in subparagraph (F) of this paragraph provided that a space of not less than 370 square feet is available for both the quiet activity room and group therapy activities.

(H) Activity service space. Space for activity services (e.g., music therapy, recreational therapy, art, dance, vocational therapy, educational therapy, etc.) shall be provided at the rate of 15 square feet per occupant of the room and a minimum area of not less than 375 square feet, whichever is greater. Space shall include provisions for hand washing, work counters, storage and displays. Where facilities contain less than 25 beds, the activity services therapy functions may be provided within the noisy activities area as required in subparagraph (F) of this paragraph if a space of not less than 485 square feet is available for both the noisy activity area and activity services area.

(I) Service areas. Service areas shall be located in, or readily available to, each nursing suite. Each service area may be arranged and located to serve more than one nursing suite but at least one service area shall be provided on each nursing floor. A service area is composed of the following.

(i) An administrative center or nurses station with an adjacent but separate dictation space.

(ii) A nurses office.

(iii) An area for charting. The charting area shall be provided with separation needed for acoustical privacy as well as space required for the function. A view window to permit observation of the patient area by the charting nurse or physician may be used provided that it is so located that patient files cannot be read from outside the charting space.

(iv) A medication room, medicine alcove area, or a self-contained medicine dispensing unit under visual control of nursing staff. The room shall have a minimum area of 30 square feet under direct control of the nursing or pharmacy staff. The room, area or unit shall contain a work counter, hand washing fixture with hands-free operable controls, and refrigerator. Provisions for security against unau-

thorized access shall be assured. Standard cup-sinks provided in many self-contained units are not adequate for hand washing.

(v) A small kitchen for patient use. The room shall contain a sink, refrigerator, ice dispenser, microwave, and storage cabinets. This room is to provide nourishment for patients between scheduled meals.

(vi) A multipurpose room for staff and patient conferences, education and demonstrations. The room shall be conveniently accessible to each nursing suite and may serve several nursing suites or departments. The room may be located on another floor if convenient for regular use.

(vii) An examination or treatment room. The room shall have a minimum floor area of 120 square feet excluding space for vestibule, toilet, and closets. The minimum room dimension shall be 10 feet. The room shall contain a lavatory or sink equipped for hand washing, work counter, storage facilities, and a desk, counter, or shelf space for writing. The emergency treatment room may be used for this purpose if it is conveniently located on the same floor as the patient rooms.

(viii) Patient laundry facilities. An automatic washer and an electric dryer shall be provided. This requirement may be omitted in nursing units intended only for adolescents and gero-psychiatric patients.

(ix) Staff lounge with separate female and male dressing areas containing lockers, showers, toilets, and hand washing facilities. These facilities may be on another floor.

(x) Securable closets or cabinet compartments for personal articles of nursing unit staff. The closets or lockers shall be located at or near the nurse station. At a minimum, these shall be large enough for purses and billfolds. Coats may be stored in closets or cabinets on each floor or in a central staff locker area.

(xi) Secured storage area for patients' effects determined potentially harmful (razors, nail files, cigarette lighters, etc.). This area shall be controlled by staff.

(xii) Clean workroom or clean supply room. When used for preparing patient care items, it shall contain a work counter, hand washing facilities, and storage facilities for clean and sterile supplies. When used only for storage and holding as part of a distribution system of clean and sterile supplies, the work counter and hand washing facilities may be omitted.

(xiii) Clean linen storage for each nursing unit. The clean linen area shall contain a work counter and storage space for clean linen. The area shall be a part of the storage and distribution of clean linen. Minimum area for clean linen shall be three square feet of room area per patient bed space. The required area may be concentrated in one central room or divided in several rooms throughout the facility.

(xiv) A soiled workroom or soiled holding room. The room shall contain a clinical sink or equivalent flushing rim fixture, hand washing facilities, both with hot and cold water. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Minimum area for soiled linen shall be three square feet of room area per patient bed space.

(xv) An equipment storage room and storage room for administrative supplies located on each floor which may serve multiple nursing suites.

(xvi) An emergency equipment storage room or alcove under direct visual control of the nursing staff and out of normal traffic.

(xvii) A housekeeping room which may also serve adjacent nursing suites.

(xviii) Stretcher and wheelchair storage space which is located without restricting normal traffic. The space may be located outside the nursing suite.

(xix) An accessible public toilet with hand washing fixtures. The toilets shall be located on each floor containing a nursing suite.

(xx) Staff toilet conveniently located to each nursing suite. At least one staff toilet shall be located on each patient sleeping floor. Toilet may be unisex.

(xxi) An ice dispensing machine for each nursing suite which is located at the nourishment station or the clean work room.

(xxii) Adequate number of drinking fountain fixtures.

(xxiii) Adequate number of telephones available for patients' private conversations.

(xxiv) A visitor room for patients to meet with friends or family with a minimum floor space of 100 square feet.

(xxv) A quiet room for a patient who needs to be alone for a short period of time but does not require a seclusion room. Each quite room shall be not less than 80 square feet. The visitor room may serve this purpose.

(xxvi) Separate consultation room. The room shall have a minimum floor space of 100 square feet, and provided at a room-to-bed ratio of one consultation room for each 12 patient beds. The room(s) shall be designed for acoustical and visual privacy and constructed to achieve a level of voice privacy of 50 STC (which in terms of vocal privacy means that some loud or raised speech is heard only by straining, but is not intelligible).

(xxvii) A conference and treatment planning room for use for patient care planning. This room may be combined with the charting room or use of the multipurpose room.

(3) Details and finishes. Details and finishes shall be in accordance with §510.122(d)(2) of this chapter and this paragraph.

(A) Details.

(i) Egress. Means of egress from each patient suite shall comply with the requirements of NFPA 101 §18-2.

(ii) Patient bathroom and toilet room doors. Door leaves to all patient bathrooms and toilet rooms shall be at least 36 inches wide and shall swing outward or be double acting so that nursing staff may gain access to a patient. Doors lockable from the inside shall have hardware that allows staff to open the door from the outside.

(iii) Vision panels. Vision panels shall be provided in the door between an anteroom and an airborne infection isolation room.

(iv) Windows. Each patient sleeping room shall have an outside window. The windows shall be restricted. Where the operation of windows requires the use of tools or keys, the tools or keys shall be located at each nurses station, on the same floor, and easily accessible to staff. The bottom of the window opening shall not exceed 36 inches above the floor.

(v) Location of patient room windows. Windows shall be located on an outside wall. Windows may face an atrium, an

inner court, or an outer court provided the following requirements are met.

(I) Atria windows. Atria onto which the required windows face shall comply with the requirements of NFPA 101 §8-2.5.6.

(II) Outer courts. Outer court (not enclosed by building on one side) onto which the required windows face shall have a minimum width, at all levels, of not less than three inches for each foot, or fraction thereof, of the height (average height of enclosing walls) of such court, but in no case shall the width be less than five feet. An outer court shall have a horizontal cross sectional area not greater than four times the square of its width.

(III) Inner courts. Inner court (enclosed by building on all sides) onto which the required windows open shall have minimum width, at all levels, of not less than one foot for each foot, or fraction thereof, of the height (average height of enclosing walls) of such courts, but in no case shall the width be less than 10 feet. If operable windows are provided, a horizontal, unobstructed, and permanently open air intake or passage having a cross-sectional area of not less than 21 square feet shall be provided at or near the bottom of the court. Metal decorative grilles not effectively reducing the open area by more than five percent shall be permitted at the ends. Walls, partitions, floor, and floor-ceiling assemblies forming intakes or passages shall be noncombustible and shall be constructed in accordance with NFPA 101 §18-3.1(b) and (c). An inner court shall have a horizontal cross sectional area of not less than one and one-half times the square of its width.

(vi) Visibility. All areas of the nursing suite, including entrances to patient rooms, shall be visible from the nurse station. Observation by video cameras of seclusion rooms, entrances, hallways, and activity areas shall be acceptable.

(vii) Special fixtures, hardware, and tamper-proof screws. Special fixtures, hardware, and tamper-proof screws shall be used throughout the patient nursing suites.

(I) All exposed and accessible fasteners shall be tamper-resistant.

(II) Suitable hardware shall be provided on doors to toilet rooms so that access to these rooms can be controlled by staff. Hardware shall be utilized which is appropriate to prevent patient injury.

(III) Only break-away or collapsible clothes bars in wardrobes, lockers, towel bars, and closets and shower curtain rods shall be permitted. Wire coat hangers shall not be permitted in nursing suites.

(IV) When grab bars are provided, the space between the grab bar and the wall should be filled to prevent a cord being tied around it for hanging. Bars, including those which are part of such fixtures as soap dishes, shall be sufficiently anchored to sustain a concentrated load of 250 pounds.

(viii) Detention screens.

(I) When operable windows are provided in patient sleeping rooms, it may be necessary to provide detention screens on windows or limit the amount of window operation in order to inhibit possible tendency for suicide or elopement. The type and the degree of security required shall be determined by the facility administration.

(II) When detention screens are provided, windows shall be capable of opening with the screens in place. Where glass fragments may create a hazard, safety glazing or other appropriate security features shall be incorporated.

(III) In building housing for certain types of patients, detention rooms, or a security section, the facility shall provide detention screens to confine or protect building inhabitants, when necessary.

(ix) Hand washing amenities. Hand washing amenities shall be conveniently located near the nurses station and in the medication area. One lavatory in an open medication area can meet this requirement.

(x) Elevator lobbies. Elevator lobbies shall be physically separated from the required means of egress with one hour fire rated construction which resist the passage of smoke on all floors containing patient rooms.

(B) Finishes.

(i) Seamless floors with coved wall bases described in §510.122(d)(2)(B)(iii)(III) of this subchapter shall be provided in soiled workrooms.

(ii) Wall bases in the soiled workroom shall be made integral and coved with the floor, tightly sealed to the wall, constructed without voids that can harbor insects, retain dirt particles, and impervious to water.

(iii) Monolithic ceilings described in §510.122(d)(2)(B)(vi)(III) of this subchapter shall be provided in airborne infection isolation rooms, seclusion rooms, and security rooms.

(iv) Ceilings of patient rooms may be acoustically treated; however, they shall be monolithic as described in §510.122(d)(2)(B)(vi)(III) of this subchapter.

(v) Acoustical ceilings shall be provided for corridors in patient areas, nurses' stations, dayrooms, recreation rooms, dining areas, and waiting areas.

(4) Mechanical requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph.

(A) Special consideration shall be given to the type of heating and cooling units, ventilations outlets, and appurtenances installed in patient-occupied areas of nursing suites. The following shall apply.

(B) All air grilles and diffusers shall be of a type that prevents the insertion of foreign objects.

(C) All convector or HVAC enclosures exposed in the room shall be constructed with rounded corners and shall have enclosures fastened with tamper-resistant fasteners.

(D) HVAC equipment shall be of a type that minimizes the need for maintenance within the room.

(E) Outside air shall be supplied to each patient room by a central air handling unit to provide make-up air for air exhausted from the bathroom in accordance with Note 3 of Table 3 of §510.131(c) of this subchapter.

(F) Each patient room bathroom shall be exhausted continuously to the exterior in accordance with Table 3 of §510.131(c) of this subchapter.

(5) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Each patient bathroom shall contain a water closet and a lavatory. The lavatory may be located in a single bed patient room instead of in the bathroom.

(B) An additional lavatory shall be placed in each patient room proper where the bathroom serves more than two beds.

(C) Hand washing fixtures shall be located near the nurses' station and the drug distribution station. One lavatory may serve both areas.

(D) Faucet controls shall not be equipped with handles that may be easily broken off in the patient care areas.

(E) Bedpan washers are not required in patient bathrooms.

(F) Piped medical gas systems are not required unless otherwise noted.

(G) Only special, tamper proof sprinkler heads from which it is not possible to suspend any objects shall be installed.

(6) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Electric receptacles in nursing units.

(i) Each receptacle shall be grounded to the reference grounding point by means of an insulated copper grounding conductor.

(ii) Each patient bed location shall be supplied by at least two branch circuits, one from the critical branch of the emergency system as required by NFPA 99, §3-4 and one from the normal system. All branch circuits from the normal system shall originate in the same panelboard.

(iii) One duplex receptacle connected to a normal branch circuit and one duplex outlet connected to the critical branch circuit shall be located on opposite sides of the head of each bed. In addition at least one duplex outlet shall be located on each wall. A dedicated outlet shall be provided at the television location.

(iv) Each examination table shall have access to two duplex receptacles.

(v) Each work table or counter shall have access to two duplex receptacles.

(vi) One duplex receptacle shall be installed in the bathroom to permit the use of electrical appliances in front of the mirror.

(vii) Receptacles shall be protected by GFCI breakers installed in distribution panel enclosures serving the nursing suite.

(viii) Duplex receptacles shall be installed not more than 50 feet apart in corridors and within 25 feet of corridor ends.

(ix) When mobile x-ray equipment is provided, special receptacles marked for X-ray use shall be installed in corridors so that mobile equipment may be used anywhere within a patient room using a cord length of 50 feet or less. Where capacitive discharge or battery powered X-ray units are used, special X-ray receptacles will not be required in corridors.

(x) Additional duplex receptacles shall be installed as required to satisfy operational needs of the nursing unit.

(B) Nurses calling systems. When a nurses calling system is provided in a nursing suite, a nurses regular calling system, nurses emergency calling system, and a staff emergency assistance calling system shall comply with §510.122(d)(5)(K) of this subchapter. Provisions shall be made for easy removal of all call buttons or for covering call buttons as required for security. Pull cords shall not exceed 18 inches in length.

(i) Each patient room shall be served by at least one nurses regular calling station for two-way voice communication. Each patient bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses calling systems shall be equipped with an indicating light at each calling station which remains lighted as long as the voice circuit is operating.

(ii) A nurses emergency calling system shall be provided at each inpatient water closet, bathtub and shower in accordance with §510.122(d)(5)(K)(ii) of this subchapter. When conveniently located one emergency call station may serve one bathroom.

(iii) A staff emergency assistance calling system for staff to summon additional assistance shall be provided in central bathing facility rooms and exam or treatment rooms in accordance with §510.122(d)(5)(K)(iii) of this subchapter.

(iv) All nurse call hardware shall have tamper resistant fasteners.

(v) A call system shall be provided at all seclusion anterooms.

(C) Illumination requirements.

(i) General illumination requirements. Nursing suite corridors shall have general illumination with provisions for reducing light levels at night. Illumination of corridors for egress purposes shall comply with NFPA 101 §§18-2.8 and 18-2.9.

(ii) Illumination of the nurses station. Illumination of the nurses station and all nursing support areas shall be with fixtures powered from the critical branch of the emergency electrical system NFPA 99 §3-4.2.2.2(c).

(iii) Patient suite lighting.

(I) Each patient room shall be provided with general lighting and night lighting. General lighting and night lighting shall be controlled at the room entrance. All controls for lighting in patient areas shall be of the quiet operating type. Control of night lighting circuits may be achieved by automatic means and in such instances control of night lighting at the room entrance shall not be required. At least one general light fixture and night lighting shall be powered from the critical branch of the essential electrical system.

(II) A reading light shall be provided for each patient. Reading light control shall be readily accessible from each patient bed. High heat producing light sources such as incandescent and halogen shall be avoided to prevent burns to patients and/or bed linen. Light sources shall be covered by a diffuser or a lens.

(III) A wall or ceiling mounted lighting fixture shall be provided above each lavatory.

(IV) A ceiling mounted fixture shall be provided in patient bathrooms where the lighting fixture above the lavatory does not provide adequate illumination of the entire bathroom. Some form of fixed illumination shall be powered from the critical branch.

(o) Pharmacy suite.

(1) Architectural requirements.

(A) General. The pharmacy room or suite shall be located for convenient access, staff control, and security for drugs and personnel.

(B) Dispensing area. The pharmacy room or suite shall include the following functional spaces and facilities:

(i) area for pickup, receiving, reviewing and recording;

(ii) extemporaneous compounding area with sufficient counter space for drug preparation and sink with hands-free operable controls;

(iii) work counter space for automated and manual dispensing activities;

(iv) storage or areas for temporary storage, exchange, and restocking of carts; and

(v) security provisions for drugs and personnel in the dispensing counter area.

(C) Manufacturing. The pharmacy room or suite shall provide the following functional spaces and facilities.

(i) When bulk compounding area is required, work space and counters shall be provided.

(ii) When packaging, labeling and quality control is required, an area(s) shall be provided.

(D) Storage. The following spaces shall be provided in cabinets, shelves, and/or separate rooms or closets:

(i) space for bulk storage, active storage, and refrigerated storage;

(ii) storage in a fire safety cabinet or storage room that is constructed under the requirements for protection from hazardous areas in accordance with NFPA 101 Chapter 12, for alcohol or other volatile fluids, when used; and

(iii) storage space for general supplies and equipment not in use.

(E) Administrative area. An administrative area for the pharmacy is optional for crisis stabilization units. The following functional spaces and facilities shall be included for the administrative area.

(i) Office area for the chief pharmacist and any other offices areas required for records, reports, accounting activities, and patients profiles.

(ii) Poison control center with storage facilities for reaction data and drug information centers.

(iii) A room or area for counseling and instruction when individual medication pick-up is available for inpatients or outpatients.

(F) Service areas. The following service areas and items shall be provided.

(i) Intravenous (IV) solutions area. When IV solutions are prepared in a pharmacy, a sterile work area with a laminar-flow workstation designed for product protection shall be provided.

(ii) Satellite pharmacy. When provided, the room shall include a work counter, a sink with hands-free operable controls, storage facilities, and refrigerator for medications.

(iii) Hand washing amenities. A hand washing fixture with hands-free operable controls shall be located in each room where open medication is handled.

(iv) Staff toilets. Toilets may be outside the suite but shall be convenient for staff use.

(2) Mechanical Requirements. Mechanical requirements shall be in accordance with §510.122(d)(3) of this subchapter and this paragraph. When IV solutions are prepared, the required laminar-flow system shall include a non-hygroscopic filter rated at 99.97% (HEPA). A pressure gauge shall be installed for detection of filter leaks or defects.

(3) Piping systems and plumbing fixtures. Piping systems and plumbing fixtures shall be in accordance with §510.122(d)(4) of this subchapter and this paragraph.

(A) Material used for plumbing fixtures shall be non-absorptive and acid-resistant.

(B) Water spouts used at lavatories and sinks shall have clearances adequate to avoid contaminating utensils and the contents of carafes, etc.

(4) Electrical requirements. Electrical requirements shall be in accordance with §510.122(d)(5) of this subchapter and this paragraph.

(A) Under-counter receptacles and conduits shall be arranged (raised) to not interfere with cleaning of the floor below or of the equipment.

(B) Exhaust hoods shall have an indicator light indicating that the exhaust fan is in operation.

(C) Electrical circuits to equipment in wet areas shall be provided with five milliampere GFCI.

(p) Rehabilitation therapy suite.

(1) Occupational therapy. When occupational therapy services are provided, the following shall be included:

(A) an activity room with work areas, counters and a hand washing fixture. Counters shall be wheel chair accessible;

(B) a storage room for supplies and equipment;

(C) secured storage for potential harmful supplies and equipment; and

(D) remote electrical switching for potentially harmful equipment.

(2) Physical therapy. When physical therapy services are provided, the following rooms shall be included.

(A) When services required by the narrative program for thermotherapy, diathermy, ultrasonics, and hydrotherapy, individual treatment areas shall be provided.

(B) An individual treatment area shall be a minimum of 70 square feet of clear floor area exclusive of four foot aisle space. Privacy screens or curtains shall be provided at each treatment station.

(C) A hand washing fixture with hands-free operable controls shall be provided in each treatment room or space. A hand washing fixture may serve several patient stations when cubicles or open room concepts are used and when the fixture is conveniently located.

(D) An area shall be provided for exercise and may be combined with treatment areas in open plan concepts.

(E) Provisions for the collection and storage of wet and soiled linen shall be provided.

(F) A storage area or room for equipment, clean linen, and supplies shall be provided.

(G) When outpatient physical therapy services are provided, the suite shall have as a minimum patient dressing areas, showers, and lockers.

(3) Service areas. The following areas or items shall be provided in a rehabilitative therapy suite but may be shared when multiple rehabilitation services are offered:

(A) patient waiting area with space for wheelchairs;

(B) patient toilet facilities containing hand washing fixtures with hands-free operable controls;

(C) reception and control stations shall be located to provide supervision of activities areas and the control station may be combined with office and clerical spaces;

(D) office and clerical space;

(E) wheelchair and stretcher storage room or alcove which shall be in addition to other storage requirements;

(F) lockable closets, lockers or cabinets for securing staff personal effects;

(G) staff toilets may be outside the suite but shall be convenient for staff use and contain hand washing fixtures with hands-free operable controls; and

(H) housekeeping room, conveniently accessible.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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CHAPTER 510. PRIVATE PSYCHIATRIC HOSPITALS AND CRISIS STABILIZATION UNITS

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §§510.81, concerning Survey and Investigation Procedures; 510.82, concerning Complaint Against a Texas Department of Health Representative; and 510.83, concerning Enforcement; and new §§510.81, concerning Integrity of Inspections and Investigations; 510.82, concerning Inspections; 510.83, concerning Complaint Investigations; 510.84, concerning Notice; 510.85, concerning Professional Conduct; 510.86, concerning Complaint Against an HHSC Representative; and 510.87, concerning Enforcement.

The repeal of §§510.81 - 510.83 and new §§510.84 - 510.86 are adopted without changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3186). These rules will not be republished.

New §§510.81 - 510.83, and 510.87 are adopted with changes to the proposed text as published in the May 10, 2024, issue of the *Texas Register* (49 TexReg 3186). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The adoption is necessary to implement House Bill (H.B.) 49, 88th Legislature, Regular Session, 2023. H.B. 49 amended Texas Health and Safety Code (HSC) §577.013 to make certain information related to facility investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

The adoption is also necessary to update the inspection, complaint investigation, and enforcement procedures for private psychiatric hospitals and crisis stabilization units (PPHCSUs). These updates are necessary to hold PPHCSUs accountable during the inspection and investigation processes and ensure PPHCSUs provide necessary documentation in a timely manner to HHSC representatives. The adopted rules revise enforcement procedures to ensure conformity with current practices and statutes. These updates also ensure consistent practices across HHSC Health Care Regulation, correct outdated language and contact information, and reflect the transition of regulatory authority for PPHCSUs from the Department of State Health Services to HHSC.

COMMENTS

The 31-day comment period ended June 10, 2024.

During this period, HHSC received comments regarding the proposed rules from six commenters, including Citizens Commission on Human Rights (CCHR), Disability Rights Texas (DRTx), Texas Association of Behavioral Health Systems (TABHS), Texas Council for Developmental Disabilities (TCDD), Texas Hospital Association (THA), and Texas Medical Association (TMA). A summary of comments relating to the rules and HHSC's responses follows.

Comment: THA expressed appreciation for HHSC considering comments from the previous public comment period and incorporating some of the feedback THA and other stakeholders provided.

Response: HHSC acknowledges this comment.

Comment: THA stated there was a possible grammatical error or missing words in §510.81(a)(2) and suggested the paragraph instead read, "may not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless it first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion."

Response: HHSC revised §510.81(a)(2) by adding "unless the facility first informs HHSC" to clarify that a facility must first inform HHSC and then obtain HHSC's written approval before beginning to record or listen to an HHSC internal discussion.

Comment: THA requested HHSC revise §510.81(b) to clarify that a facility must only inform HHSC of audio-capturing recording devices that are not readily visible. THA stated security cameras are present in many locations in facilities, particularly hallways and common areas, and that it is possible cameras may be present while HHSC staff are having discussions. THA noted cameras in common areas would be visible to anyone and likely

do not capture audio and should not require disclosure by the facility.

Response: HHSC declines to revise §510.81(b) because HHSC staff need enhanced privacy for internal discussion and this paragraph is necessary to protect HHSC staff from intentional or unintentional eavesdropping.

Comment: TABHS requested HHSC clarify to whom the term "individual" applies in §510.81(d) and asked whether the term referred to a facility staff member, a patient, an HHSC representative, or all the above. TABHS also stated it supports the rights of staff members and patients to record conversations with HHSC representatives.

Response: HHSC declines to revise §510.81(d) and notes that "individual" refers to anyone.

Comment: TABHS requested HHSC clarify whether a facility may allow HHSC to interview governing body members, facility personnel, and patients through virtual methods in §510.82(f) and §510.83(h).

Response: HHSC declines to revise §510.82(f) and §510.83(h) because as written, these subsections do not preclude a facility from providing HHSC access to interview governing body members, personnel, and patients through virtual methods.

Comment: THA expressed concern about §510.82(f) and §510.83(h), which require a facility to permit HHSC access to interview members of a facility's governing body, personnel, and patients, including the opportunity to request written statements. THA stated members of facility governing bodies are often community members not involved in the facility's daily operations and subjecting them to interviews may deter community involvement in facility boards. THA further stated that requesting written statements from personnel and governing body members could lead to disputes and potential enforcement actions if statements are not provided or deemed unsatisfactory. THA requested HHSC remove the provisions allowing interviews with governing body members and the requirement for written statements to avoid potential adversarial situations if a facility declines HHSC's request.

Response: HHSC declines to revise §510.82(f) and §510.83(h) because it is important for HHSC staff to have the opportunity to talk to and request statements from relevant individuals, including, at times, members of a facility's governing body. HHSC notes these subsections do not require a written statement and only allows HHSC the opportunity to request one.

Comment: TABHS suggested HHSC add language to §510.82(g) and §510.83(i) to allow a facility to make copies of any documents or other records if needed before HHSC removes that information from the facility, particularly if they are clinician notes and other documentation necessary for patient care.

Response: HHSC declines to revise §510.82(g) and §510.83(i) because as written, these subsections do not prohibit a facility from making copies of any documents or records before HHSC removes them from the facility.

Comment: TABHS requested HHSC add language to §510.82(j) and §510.83(k) to ensure a facility has an opportunity for another exit conference to provide documentation regarding compliance for any preliminary findings that were not discussed during the original exit conference. TABHS stated HHSC currently does not ensure facilities have the right to provide additional documentation for any preliminary findings not discussed during the original exit conference.

Response: HHSC declines to revise §510.82(j) and §510.83(k) because the facility is entitled to due process, which allows for the facility to follow up and provide more documentation after HHSC completes the inspection or issues a citation.

Comment: THA questioned whether HHSC disclosing information to law enforcement agencies as allowed by §510.82(k)(4) and §510.83(m)(4) is appropriate or legally permissible. However, THA noted the statutory language supported this exception. THA stated that the Health Insurance Portability and Accountability Act (HIPAA) provides limited exceptions for disclosures to law enforcement, typically requiring specific legal processes like search warrants or subpoenas. THA further stated that the proposed rule may not comply with HIPAA and HSC §181.004. THA requested HHSC remove §510.82(k)(4) and §510.83(m)(4) because THA does not believe it is appropriate for HHSC to have rules specifically permitting the disclosure of confidential information to a law enforcement agency. Alternatively, THA requested HHSC revise §510.82(k)(4) and §510.83(m)(4) to state "law enforcement agencies as otherwise authorized or required by law."

Response: HHSC revised §510.82(k)(4) and §510.83(m)(4) to add "as allowed by law" to the end of the paragraph.

Comment: CCHR expressed support for the inclusion of language added by H.B. 49, 88th Regular Session, 2023 at §510.82(l) and §510.83(n). H.B. 49 amended Texas Health and Safety Code (HSC) §241.051 to make certain information related to hospital investigations subject to disclosure and create a requirement for HHSC to post certain information related to hospital investigations on the HHSC website.

Response: HHSC acknowledges this comment.

Comment: TMA stated that §510.82(l) and §510.83(n) tracked the governing statute except for §510.82(l)(6) and §510.83(n)(6). TMA further stated Texas Government Code Chapter 552 generally gives the public the right to access government information on request, so §510.82(l)(6) and §510.83(n)(6) would make all inspection and investigation information, other than certain personally identifying information, subject to public disclosure, which conflicts with HSC §577.013(e). TMA recommended that §510.82(l)(6) and §510.83(n)(6) be removed to properly align with HSC §577.013(e).

Response: HHSC declines to remove §510.82(l)(6) and §510.83(n)(6) because these paragraphs state that HHSC will follow the requirements of public information laws, which prohibit disclosure of information made confidential by other laws, such as HSC §577.013(e). These paragraphs do not authorize disclosure of any information contrary to those laws.

Comment: THA expressed concern with the posting requirements at §510.83(a)(2) because the requirements will take time for facilities to implement and there is a possible conflict with an existing rule at 25 TAC §1.191, which also mandates signage to notify patients where they can file complaints. THA requested HHSC withdraw §510.83(a)(2), review the rule at 25 TAC §1.191 alongside proposed §510.83(a)(2), and propose a unified rule that avoids duplicative or conflicting signage mandates. Alternatively, THA proposed an extended implementation period of at least 12 months for facilities to comply with the signage requirements and for HHSC to provide guidance on how to reconcile the two rules.

Response: HHSC declines to remove §510.83(a)(2) because HHSC does not enforce 25 TAC §1.191 regarding PPHCSUs. Section 510.83(a)(2) applies to facilities regulated by HHSC, and 25 TAC §1.191 applies to facilities regulated by DSHS.

Comment: DRTx recommended HHSC revise §510.83(d) by adding language regarding HHSC's duty to complete regulatory investigations regardless of the Centers for Medicare & Medicaid Service (CMS) authorization. DRTx stated that HHSC and other state agencies have the authority and receive state funding to complete their responsibilities for facility investigations and regulatory oversight. DRTx further stated it is the responsibility of the state regulatory agency to protect Texas's vulnerable citizens, and HHSC should investigate allegations meeting the definitions of abuse and neglect in Texas law, even if CMS does not authorize an investigation. DRTx expressed concern with HHSC referring investigations of complaints involving psychiatric facilities that HHSC chose not to investigate to the Joint Commission. DRTx stated the Joint Commission is an accrediting body and does not perform investigations of abuse or neglect consistent with Texas regulations. DRTX also stated CMS does not provide any information about any investigation, review, or action on such referrals. DRTx stated such referrals result in the allegations not being addressed by any investigatory entity.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §510.83(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with §510.46, 25 TAC Chapter 1, Subchapter Q, and HHSC internal policies.

Comment: Regarding §510.83(d), CCHR stated Texas has its own unique statutes and HHSC has the right, duty, and budget to investigate complaints that are not related to CMS Conditions of Participation. CCHR stated CMS funding should not play a role in HHSC choosing whether to investigate a complaint. CCHR also noted that it was aware of complaints that were referred to the Joint Commission and complaints should not be referred to the Joint Commission in lieu of investigation because the Joint Commission is an industry paid accreditation organization and not a regulatory organization.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2) but does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with Chapter 510 and HHSC internal policies.

Comment: TCDD recommended HHSC revise §510.83(d) to add language regarding HHSC's duty to complete investigations regardless of CMS authorization and language prohibiting HHSC from delegating its investigatory responsibilities to any other entity. TCCD stated in the rule, HHSC did not acknowledge the state regulatory agency's responsibility to protect vulnerable Texans in psychiatric hospitals and CSUs or assert its responsibility for investigations without CMS authorization or payment from any other entity, including CMS. TCDD expressed its concern with the delegation of investigations to the Joint Commission, which TCDD stated is not a regulatory or investigatory body and does not conduct investigations of abuse and neglect consistent with Texas regulations. TCDD stated these referred allegations are not being addressed by any investigatory entity.

Response: HHSC declines to revise §510.83(d) because this subsection allows for coordination with CMS in accordance with HSC §222.026(a)(2), but §510.83(d) does not preclude HHSC from conducting investigations independent of CMS or from meeting the agency's responsibilities for conducting investigations in accordance with Chapter 510 and HHSC internal policies.

Comment: THA requested HHSC extend the timeframe for facilities to submit a plan of correction (POC) under §510.84(b)(2) because THA stated the proposed 10 calendar day timeframe was too compressed to develop an extensive POC and implementation plan. THA suggested language that would lengthen the timeframe to 30 calendar days for deficiencies that did not affect patient health and safety and language to allow flexibility for HHSC to require a shorter timeframe, but no earlier than 10 calendar days, for more urgent issues affecting or potentially affecting patient health and safety.

Response: HHSC declines to revise §510.84(b)(2) because 10 calendar days after receipt of a statement of deficiencies (SOD) is sufficient time to provide HHSC with a POC. HHSC notes a facility is made aware of the issues HHSC found and the potential citations at the exit conference so the facility can begin working on correcting any issues even before receipt of the SOD.

Comment: TMA stated §510.85 appears to impose reporting mandates on HHSC. TMA stated not every issue relating to the conduct of a licensed professional, intern, or application for professional licensure will necessarily warrant reporting to the licensing board. TMA recommended replacing "reports" with "may report" in §510.85 to allow HHSC to exercise discretion in its reporting.

Response: HHSC declines to revise §510.85 because the agency prefers to err on the side of caution regarding conduct of licensed professionals. HHSC notes licensing boards have discretion in responding to any complaint.

Comment: THA expressed concern with §510.86 not including the details related to HHSC's internal procedures regarding complaints against an HHSC representative, currently found at §510.82. THA stated it is important for facilities to understand how HHSC handles complaints against surveyors or investigators, including clear expectations for HHSC's response timeframe. THA requested HHSC include procedural details in the final rule to ensure transparency and provide facilities with an opportunity to provide input. Additionally, THA suggested the rule include clear anti-retaliation language to protect facilities or individuals filing complaints, and proposed language prohibiting retaliation by HHSC or HHSC representatives against facilities or persons filing a complaint against an HHSC representative.

Response: HHSC declines to revise §133.106 as requested because the agency investigates complaints against HHSC representatives immediately on receipt and in accordance with its policies, which include requiring staff to perform their duties in a lawful, professional, and ethical manner.

Comment: TCDD stated §510.87 is missing several pertinent chapters and conflicts with §510.46, which states that HHSC will not investigate allegations that are not a violation of Chapters 571 or 577 and will refer those allegations to law enforcement or another agency. TCCD recommended also referencing HSC Chapters 161, 321, and 322 in §510.87 because these chapters also apply to psychiatric hospitals.

Response: HHSC revised §510.87 as suggested to include HSC Chapters 161, 321, and 322.

Comment: THA expressed concern with §510.87(1)(O) and stated participation in Medicare is voluntary and should not be a criterion for licensing decisions or penalties. THA requested HHSC remove this paragraph because THA stated a facility terminating the facility's Medicare provider agreement should not jeopardize the facility's licensure status or result in penalties.

Response: HHSC revised §510.87(1)(O) to clarify this subparagraph applies if CMS terminates the facility's Medicare provider agreement.

Comment: THA expressed concern with §510.87(2)(B)(ii) because THA stated the category is overly broad and that it is not uncommon for providers to make unintentional billing errors that result in Medicare sanctions, and in those cases the provider repays any amounts owed and associated penalties and is free to continue participating in the Medicare program. Further, THA stated other regulatory infractions of Medicare Conditions of Participation may result in citations and sanctions and penalties that are inconsequential and do not justify denying a facility license.

Response: HHSC declines to revise §510.87(2)(B)(ii) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

Comment: THA requested HHSC revise §510.87(2)(B)(iii) to state "federal or state tax liens that are unsatisfied after all avenues of dispute have been exhausted" because THA stated the category is overly broad and stated that the facility may not have had the opportunity to dispute a lien and HHSC could deny the facility's license for an unresolved lien for which a dispute is pending.

Response: HHSC declines to revise §510.87(2)(B)(iii) because unsatisfied federal or state tax liens could indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC remove §510.87(2)(B)(iv) because THA stated the category is overly broad because there is no threshold amount in controversy, it does not account for audit exceptions that are still being disputed, civil judgments may be taken for many reasons that would have no bearing on the fitness to operate a facility, and final judgments could still be on appeal and therefore be technically unsatisfied. Alternatively, THA requested HHSC revise this clause to specify the specific types of judgments that could result in denial and account for final judgments that may be on appeal and suggested for the rule to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted."

Response: HHSC declines to remove or revise §510.87(2)(B)(iv) because this clause provides HHSC regulatory oversight and could also indicate that an applicant or licensee cannot meet their financial obligations, which may create health and safety concerns.

Comment: THA requested HHSC revise §510.87(2)(B)(vi) to state "federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted." THA stated this clause is overly broad because there is no threshold amount in controversy, and it does not account for audit exceptions that are still being disputed.

Response: HHSC declines to revise §510.87(2)(B)(vi) because HHSC has jurisdiction to enforce violations if the facility discloses actions that could result in HHSC denying a license application or suspending or revoking a facility's license.

HHSC revised §510.81(a)(1) to connect paragraphs (1) and (2) with "or" instead of "and." HHSC made this change to ensure consistency with the freestanding emergency medical care facility rule at 26 TAC §509.81 and the limited services hospital rule at 26 TAC §511.111(a).

HHSC revised §510.82(e) and §510.83(g) by adding "video surveillance" to the list of items a facility must permit HHSC to examine during any HHSC inspection or investigation. This change is made so that the list in §510.82(e) and §510.83(g) is consistent with other HHSC rules in this rule project and the list in 26 TAC §511.112(e) for a limited services rural hospital.

HHSC revised §510.82(l)(6) and §510.83(n)(6) to remove the word "request" because the laws are about public information laws and not public information request laws.

HHSC revised §510.82 to add new subsection (p) which states HHSC will notify a complainant within 10 business days after completing the investigation of the investigation's outcome.

SUBCHAPTER E. ENFORCEMENT

26 TAC §§510.81 - 510.83

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

26 TAC §§510.81 - 510.87

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §577.010, which requires HHSC to adopt rules and standards necessary and appropriate to ensure the proper care and treatment of patients in a private mental hospital or mental health facility.

§510.81. Integrity of Inspections and Investigations.

(a) In order to preserve the integrity of the Texas Health and Human Services Commission's (HHSC's) inspection and investigation process, a facility:

(1) shall not record, listen to, or eavesdrop on any HHSC interview with facility staff or patients that the facility staff knows HHSC intends to keep confidential as evidenced by HHSC taking reasonable measures to prevent from being overheard; or

(2) shall not record, listen to, or eavesdrop on any HHSC internal discussions outside the presence of facility staff when HHSC has requested a private room or office or distanced themselves from facility staff unless the facility first informs HHSC and the facility obtains HHSC's written approval before beginning to record or listen to the discussion.

(b) A facility shall inform HHSC when security cameras or other existing recording devices in the facility are in operation during any internal discussion by or among HHSC staff.

(c) When HHSC by words or actions permits facility staff to be present, an interview or conversation for which facility staff are present does not constitute a violation of this rule.

(d) This section does not prohibit an individual from recording an HHSC interview with the individual.

§510.82. Inspections.

(a) The Texas Health and Human Services Commission (HHSC) may conduct an inspection of a facility prior to the issuance or renewal of a license.

(1) A hospital is not subject to additional annual licensing inspections subsequent to the issuance of the initial license while the hospital maintains:

(A) certification under Title XVIII of the Social Security Act, 42 United States Code (USC) §1395 et seq.; or

(B) accreditation from The Joint Commission, the American Osteopathic Association, or other national accreditation organization for the offered services.

(2) HHSC may conduct an inspection of a hospital exempt from an annual licensing inspection under paragraph (1) of this subsection before issuing a renewal license to the hospital if the certification or accreditation body has not conducted an on-site inspection of the hospital in the preceding three years and HHSC determines that an inspection of the hospital by the certification or accreditation body is not scheduled within 60 days of the license expiration date.

(b) HHSC may conduct an unannounced, on-site inspection of a facility at any reasonable time, including when treatment services are provided, to inspect, investigate, or evaluate compliance with or prevent a violation of:

(1) any applicable statute or rule;

(2) a facility's plan of correction;

(3) an order or special order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(c) An applicant or licensee, by applying for or holding a license, consents to entry and inspection of any of its facilities by HHSC.

(d) HHSC inspections to evaluate a facility's compliance may include:

(1) initial, change of ownership, or relocation inspections for the issuance of a new license;

(2) inspections related to changes in status, such as new construction or changes in services, designs, or bed numbers;

(3) routine inspections, which may be conducted without notice and at HHSC's discretion, or prior to renewal;

(4) follow-up on-site inspections, conducted to evaluate implementation of a plan of correction for previously cited deficiencies;

(5) inspections to determine if an unlicensed facility is offering or providing, or purporting to offer or provide, treatment; and

(6) entry in conjunction with any other federal, state, or local agency's entry.

(e) A facility shall cooperate with any HHSC inspection and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by or on behalf of the facility, unless prohibited by law.

(f) A facility shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(g) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(h) Upon entry, HHSC holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the inspection.

(i) During the inspection, the HHSC representative gives the facility representative an opportunity to submit information and evidence relevant to matters of compliance being evaluated.

(j) When an inspection is complete, the HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the inspection, including any possible health and safety concerns. The facility may provide any final documentation regarding compliance during the exit conference.

(k) HHSC shall maintain the confidentiality of facility records as applicable under state or federal law. Except as provided by subsection (l) of this section, all information and materials in the possession of or obtained or compiled by HHSC in connection with an inspection are confidential and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the facility;

(2) the facility that is the subject of the enforcement action, or the facility's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate licensed mental health facility services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying information and information identifying the facility has been deleted.

(l) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the facility's alleged violation, which must include the provisions of law the facility is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC conducted of the facility;

(3) the pleadings in any administrative proceeding to impose a penalty against the facility for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the facility, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision, investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(m) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a facility's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §577.013.

§510.83. Complaint Investigations.

(a) A facility shall provide each patient and applicable legally authorized representative at the time of admission with a written statement identifying the Texas Health and Human Services Commission (HHSC) as the agency responsible for investigating complaints against the facility.

(1) The statement shall inform persons that they may direct a complaint to HHSC Complaint and Incident Intake (CII) and include current CII contact information, as specified by HHSC.

(2) The facility shall prominently and conspicuously post this statement in patient common areas and in visitor's areas and waiting rooms so that it is readily visible to patients, employees, and visitors. The information shall be in English and in a second language appropriate to the demographic makeup of the community served.

(b) HHSC evaluates all complaints. A complaint must be submitted using HHSC's current CII contact information for that purpose, as described in subsection (a) of this section.

(c) HHSC documents, evaluates, and prioritizes complaints directed to HHSC CII based on the seriousness of the alleged violation and the level of risk to patients, personnel, and the public.

(1) Allegations determined to be within HHSC's regulatory jurisdiction relating to health care facilities may be investigated under this chapter.

(2) HHSC may refer complaints outside HHSC's jurisdiction to an appropriate agency, as applicable.

(d) HHSC conducts investigations to evaluate a facility's compliance following a complaint of abuse, neglect, or exploitation; or a complaint related to the health and safety of patients. Complaint investigations may be coordinated with the federal Centers for Medicare & Medicaid Services and its agents responsible for the inspection of hospitals to determine compliance with the Conditions of Participation under Title XVIII of the Social Security Act, (42 USC, §1395 et seq.), so as to avoid duplicate investigations.

(e) HHSC may conduct an unannounced, on-site investigation of a facility at any reasonable time, including when treatment services are provided, to inspect or investigate:

(1) a facility's compliance with any applicable statute or rule;

(2) a facility's plan of correction;

(3) a facility's compliance with an order of the HHSC executive commissioner or the executive commissioner's designee;

(4) a facility's compliance with a court order granting injunctive relief; or

(5) for other purposes relating to regulation of the facility.

(f) An applicant or licensee, by applying for or holding a license, consents to entry and investigation of any of its facilities by HHSC.

(g) A facility shall cooperate with any HHSC investigation and shall permit HHSC to examine the facility's grounds, buildings, books, records, video surveillance, and other documents and information maintained by, or on behalf of, the facility, unless prohibited by law.

(h) A facility shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement.

(i) A facility shall permit HHSC to inspect and copy any requested information, unless prohibited by law. If it is necessary for HHSC to remove documents or other records from the facility, HHSC provides a written description of the information being removed and when it is expected to be returned. HHSC makes a reasonable effort, consistent with the circumstances, to return any records removed in a timely manner.

(j) Upon entry, the HHSC representative holds an entrance conference with the facility's designated representative to explain the nature, scope, and estimated duration of the investigation.

(k) The HHSC representative holds an exit conference with the facility representative to inform the facility representative of any preliminary findings of the investigation. The facility may provide any final documentation regarding compliance during the exit conference.

(l) Once an investigation is complete, HHSC reviews the evidence from the investigation to evaluate whether there is a preponderance of evidence supporting the allegations contained in the complaint.

(m) HHSC shall maintain the confidentiality of facility records as applicable under state or federal law. Except as provided by (n) of this subsection, all information and materials in the possession of or obtained or compiled by HHSC in connection with an investigation are confidential and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than HHSC or its employees or agents involved in the enforcement action except that this information may be disclosed to:

(1) persons involved with HHSC in the enforcement action against the facility;

(2) the facility that is the subject of the enforcement action, or the facility's authorized representative;

(3) appropriate state or federal agencies that are authorized to inspect, survey, or investigate licensed mental health facility services;

(4) law enforcement agencies as allowed by law; and

(5) persons engaged in bona fide research, if all individual-identifying information and information identifying the facility has been deleted.

(n) The following information is subject to disclosure in accordance with Texas Government Code Chapter 552, only to the extent that all personally identifiable information of a patient or health care provider is omitted from the information:

(1) a notice of the facility's alleged violation, which must include the provisions of law the facility is alleged to have violated, and a general statement of the nature of the alleged violation;

(2) the number of investigations HHSC has conducted of the facility;

(3) the pleadings in any administrative proceeding to impose a penalty against the facility for the alleged violation;

(4) the outcome of each investigation HHSC conducted of the facility, including:

(A) reprimand issuance;

(B) license denial or revocation;

(C) corrective action plan adoption; or

(D) administrative penalty imposition and the penalty amount;

(5) a final decision investigative report, or order issued by HHSC to address the alleged violation; and

(6) any other information required by law to be disclosed under public information laws.

(o) Within 90 days after the date HHSC issues a final decision, investigative report, or order to address a facility's alleged violation, HHSC posts certain information on the HHSC website in accordance with Texas Health and Safety Code §577.013.

(p) HHSC notifies complainants regarding the investigation's outcome within 10 business days after completing the investigation.

§510.87. Enforcement.

Enforcement is a process by which a sanction is proposed, and if warranted, imposed on an applicant or licensee regulated by the Texas Health and Human Services Commission (HHSC) for failure to comply with applicable statutes, rules, and orders.

(1) Denial, suspension or revocation of a license or imposition of an administrative penalty. HHSC has jurisdiction to enforce violations of Texas Health and Safety Code (HSC) Chapters 571 through 578 or the rules adopted under these chapters. HHSC may deny, suspend, or revoke a license or impose an administrative penalty for:

(A) failure to comply with any applicable provision of the HSC, including Chapters 161, 321, 322, and 571 through 578;

(B) failure to comply with any provision of this chapter or any other applicable laws;

(C) the facility, or any of its employees, committing an act which causes actual harm or risk of harm to the health or safety of a patient;

(D) the facility, or any of its employees, materially altering any license issued by HHSC;

(E) failure to comply with minimum standards for licensure;

(F) failure to provide a complete license application;

(G) failure to comply with an order of the executive commissioner or another enforcement procedure under HSC Chapters 571 through 578;

(H) a history of failure to comply with the applicable rules relating to patient environment, health, safety, and rights;

(I) the facility aiding, committing, abetting, or permitting the commission of an illegal act;

(J) the facility, or any of its employees, committing fraud, misrepresentation, or concealment of a material fact on any documents required to be submitted to HHSC or required to be maintained by the facility pursuant to HSC Chapters 571 through 578 and the provisions of this chapter;

(K) failure to timely pay an assessed administrative penalty as required by HHSC;

(L) failure to submit an acceptable plan of correction for cited deficiencies within the timeframe required by HHSC;

(M) failure to timely implement plans of corrections to deficiencies cited by HHSC within the dates designated in the plan of correction;

(N) failure to comply with applicable requirements within a designated probation period; or

(O) if the facility is participating under Title XVIII of the Social Security Act, 42 United States Code (USC), §1395 et seq., the Centers for Medicare & Medicaid Services terminating the facility's Medicare provider agreement.

(2) Denial of a license. HHSC has jurisdiction to enforce violations of HSC Chapters 571 through 578 or the rules adopted under this chapter. HHSC may deny a license if the applicant:

(A) fails to provide timely and sufficient information required by HHSC that is directly related to the license application; or

(B) has had the following actions taken against the applicant within the two-year period preceding the license application:

(i) decertification or cancellation of its contract under the Medicare or Medicaid program in any state;

(ii) federal Medicare or state Medicaid sanctions or penalties;

(iii) unsatisfied federal or state tax liens;

(iv) unsatisfied final judgments;

(v) eviction involving any property or space used as a hospital in any state;

(vi) unresolved federal Medicare or state Medicaid audit exceptions;

(vii) denial, suspension, or revocation of a hospital license, a private psychiatric hospital license, or a license for any health care facility in any state; or

(viii) a court injunction prohibiting ownership or operation of a facility.

(3) Order for immediate license suspension. HHSC may suspend a license for 10 days pending a hearing if after an investigation HHSC finds that there is an immediate threat to the health or safety of the patients or employees of a licensed facility. HHSC may issue necessary orders for the patients' welfare.

(4) Probation. In lieu of denying, suspending, or revoking a license, HHSC may place a facility on probation for a period of not less than 30 days, if HHSC finds that the facility is in repeated noncompliance with this chapter or HSC Chapters 571 through 578 and the facility's noncompliance does not endanger the public's health and safety.

(A) HHSC shall provide notice to the facility of the probation and of the items of noncompliance not later than the 10th day before the date the probation period begins.

(B) During the probation period, the facility shall correct the items of noncompliance and report the corrections to HHSC for approval.

(5) Administrative penalty. HHSC has jurisdiction to impose an administrative penalty against a person licensed or regulated under this chapter for violations of applicable chapters of the HSC or this chapter. The imposition of an administrative penalty shall be in accordance with the provisions of HSC §571.025.

(6) Licensure of persons or entities with criminal backgrounds. HHSC may deny a person or entity a license or suspend or revoke an existing license on the grounds that the person or entity has been convicted of a felony or misdemeanor that directly relates to the duties and responsibilities of the ownership or operation of a facility. HHSC shall apply the requirements of Texas Occupations Code Chapter 53.

(A) HHSC is entitled under Texas Government Code Chapter 411 to obtain criminal history information maintained by the Texas Department of Public Safety, the Federal Bureau of Investigation, or any other law enforcement agency to investigate the eligibility of an applicant for an initial or renewal license and to investigate the continued eligibility of a licensee.

(B) In determining whether a criminal conviction directly relates, HHSC shall apply the requirements and consider the provisions of Texas Occupations Code Chapter 53 (relating to Consequences of Criminal Conviction).

(C) The following felonies and misdemeanors directly relate to the duties and responsibilities of the ownership or operation of a health care facility because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate a facility:

(i) a misdemeanor violation of HSC Chapter 571;

(ii) a misdemeanor or felony involving moral turpitude;

(iii) a misdemeanor or felony relating to deceptive business practices;

(iv) a misdemeanor or felony of practicing any health-related profession without a required license;

(v) a misdemeanor or felony under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(vi) a misdemeanor or felony under Texas Penal Code (TPC), Title 5, involving a patient or a client of any health care facility, a home and community support services agency, or a health care professional; or

(vii) a misdemeanor or felony under TPC:

(I) Title 4;

(II) Title 5;

(III) Title 7;

(IV) Title 8;

(V) Title 9;

(VI) Title 10; or

(VII) Title 11.

(7) Offenses listed in paragraph (6)(C) of this section are not exclusive in that HHSC may consider similar criminal convictions from other state, federal, foreign or military jurisdictions that indicate an inability or tendency for the person or entity to be unable to own or operate a facility.

(8) HHSC shall revoke a license on the licensee's imprisonment following a felony conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision.

(9) Notice. If HHSC proposes to deny, suspend, or revoke a license, or impose an administrative penalty, HHSC shall send a notice of the proposed action by certified mail, return receipt requested, at the address shown in the current records of HHSC or HHSC may personally deliver the notice. The notice to deny, suspend, or revoke a license, or impose an administrative penalty, shall state the alleged facts or conduct to warrant the proposed action, provide an opportunity to demonstrate or achieve compliance, and shall state that the applicant or license holder has an opportunity for a hearing before taking the action.

(10) Acceptance. Within 20 calendar days after receipt of the notice described in paragraph (9) of this section, the applicant or licensee shall notify HHSC, in writing, of acceptance of HHSC's determination or request a hearing.

(11) Hearing request.

(A) A request for a hearing by the applicant or licensee shall be in writing and submitted to HHSC within 20 calendar days after receipt of the notice described in paragraph (9) of this section. Receipt of the notice is presumed to occur on the third day after the date HHSC mails the notice to the last known address of the applicant or licensee.

(B) A hearing shall be conducted pursuant to Texas Government Code Chapter 2001, and Texas Administrative Code Title 1 Chapter 357, Subchapter I (relating to Hearings under the Administrative Procedure Act).

(12) No response to notice. If an applicant or licensee does not request a hearing in writing within 20 calendar days after receiving notice of the proposed action, the applicant or licensee is deemed to have waived the opportunity for a hearing and HHSC takes the proposed action.

(13) Notification of HHSC's final decision. HHSC shall send the licensee or applicant a copy of HHSC's decision for denial, suspension or revocation of license or imposition of an administrative penalty by certified mail, which shall include the findings of fact and conclusions of law on which HHSC based its decision.

(14) Admission of new patients upon suspension or revocation. Upon HHSC's determination to suspend or revoke a license, the license holder may not admit new patients until the license is reissued.

(15) Decision to suspend or revoke. When HHSC's decision to suspend or revoke a license is final, the licensee must imme-

diately cease operation, unless a stay of such action is issued by the district court.

(16) Return of original license. Upon suspension, revocation or non-renewal of the license, the original license shall be returned to HHSC within 30 calendar days of HHSC's notification.

(17) Reapplication following denial or revocation.

(A) One year after HHSC's decision to deny or revoke, or the voluntary surrender of a license by a facility while enforcement action is pending, a facility may petition HHSC, in writing, for a license. Expiration of a license prior to HHSC's decision becoming final shall not affect the one-year waiting period required before a petition can be submitted.

(B) HHSC may allow a reapplication for licensure if there is proof that the reasons for the original action no longer exist.

(C) HHSC may deny reapplication for licensure if HHSC determines that:

(i) the reasons for the original action continues;

(ii) the petitioner has failed to offer sufficient proof that conditions have changed; or

(iii) the petitioner has demonstrated a repeated history of failure to provide patients a safe environment or has violated patient rights.

(D) If HHSC allows a reapplication for licensure, the petitioner shall be required to meet the requirements as described in §510.22 of this chapter (relating to Application and Issuance of Initial License).

(18) Expiration of a license during suspension. A facility whose license expires during a suspension period may not reapply for license renewal until the end of the suspension period.

(19) Surrender of a license. In the event that enforcement, as defined in this subsection, is pending or reasonably imminent, the surrender of a facility license shall not deprive HHSC of jurisdiction in regard to enforcement against the facility.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 10, 2024
For further information, please call: (512) 834-4591

CHAPTER 745. LICENSING
SUBCHAPTER N. ADMINISTRATOR'S LICENSING
DIVISION 7. REMEDIAL ACTIONS
26 TAC §745.9037

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §745.9037, concerning Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application.

The amendment to §745.9037 is adopted without changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5313). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

The amendment is necessary to implement House Bill (H.B.) 4170, 88th Legislature, Regular Session, 2023. H.B. 4170 amended Texas Human Resources Code (HRC) §43.010(b), which makes a person ineligible to apply for another administrator's license for five years after the date HHSC refused to renew the administrator's license. Prior to this amendment, this subsection only applied the five-year ban to when HHSC revoked an administrator's license. The amendment to §745.9037 is necessary for this rule to be consistent with HRC §43.010(b).

COMMENTS

The 31-day comment period ended August 19, 2024.

During this period, HHSC received a comment regarding the proposed rule from one commenter, Texas Alliance of Child and Family Services (TACFS). A summary of the comment relating to the rule and HHSC's response follows.

Comment: The commenter expressed concerns regarding the implementation of the amendment, as the grounds for refusal to renew are subjective and unclear, and the organization believes there is no clear explanation for what it means in §745.9031(a)(3) for an administrator to not be in compliance with the laws or rules governing the license. TACFS believes this makes it difficult for operations to begin serving children and makes it harder for the state to build and retain high-quality residential child-care settings.

Response: HHSC disagrees and declines to revise §745.9037 because it is outside the scope of this rule project. Amended §745.9037(b) will be consistent with current statutory language, and the comment is not relevant to this objective.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and HRC §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43, HRC.

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

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

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Karen Ray
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CHAPTER 746. MINIMUM STANDARDS FOR CHILD-CARE CENTERS

SUBCHAPTER D. PERSONNEL

DIVISION 1. CHILD-CARE CENTER DIRECTOR

26 TAC §§746.1053, 746.1065, 746.1067, 746.1069

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §746.1053, concerning Will the director's certificate expire; and new §746.1065, concerning What is an interim director, §746.1067, concerning When may a child-care center designate someone as the interim director of the center, and §746.1069, concerning May someone serving as interim director of a child-care center continue to serve as director after the center receives a full license.

Amended §746.1053; and new §§746.1065, 746.1067, and 746.1069 are adopted with changes to the proposed text as published in the July 19, 2024, issue of the *Texas Register* (49 TexReg 5315). These rules will be republished.

BACKGROUND AND JUSTIFICATION

The amendment and new sections are necessary to comply with Senate Bill (S.B.) 1327, 88th Legislature, Regular Session, 2023. S.B. 1327 amended Texas Human Resources Code (HRC), Chapter 42, by adding §42.04201 and amending §42.0761(a). HRC §42.04201 allows a child-care center operating under an initial license to designate an individual who meets all the director qualifications, except the education requirement, to serve as an interim director. Since an initial license is valid for six months from the date that HHSC Child Care Regulation (HHSC CCR) issues it and may be renewed for an additional six months, the statute allows a person to serve as an interim director for up to 12 months. Before the prospective 12-month period expires, the interim director may obtain the education requirements and be designated as a qualified director. If the interim director does not meet the education requirements at the end of the 12-month period, the child-care center must obtain an approved waiver for the requirements or employ a new director. HRC §42.0761(a) adds the term "interim director" to the statute that requires a child-care center to designate a qualified director who is routinely present at the operation.

HHSC CCR is adopting new rules in Chapter 746 to provide a definition of "interim director" and describe the requirements related to qualifying for that designation. HHSC CCR is also adopting an amendment to one rule related to expiring director certificates.

COMMENTS

The 31-day comment period ended August 19, 2024. During this period, HHSC received one comment regarding the proposed rules from one individual. A summary of the comment relating to the rules and the HHSC response follows.

Comment: Regarding §746.1069, one commenter stated that an interim director should be able to obtain a full director qualification after a year if that person submitted information to become a director at the time the child-care center opened.

Response: HHSC disagrees with the comment and declines to revise the rule. HHSC must align the rule with HRC §42.04201, which requires an individual to meet educational requirements or request a waiver to transition from an interim director to a director once the child-care center receives a full license. The statute does not provide an allowance for additional experience in the child-care center in lieu of educational requirements.

In addition, HHSC made minor editorial changes to replace first-person ("I," "me," "we," or "us") and second-person ("you," "your," or "yours") pronouns in §§746.1053, 746.1065, 746.1067, and 746.1069.

STATUTORY AUTHORITY

The amendment and new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §531.033, which requires the Executive Commissioner to adopt rules necessary to carry out HHSC duties under Chapter 531 of Texas Government Code. In addition, HRC §42.042(a) requires HHSC to adopt rules to carry out the requirements of Chapter 42 of HRC.

§746.1053. Will the director's certificate expire?

The director's certificate will not expire unless the director was qualified:

(1) Under (5) or (6) in Figure: 26 TAC §746.1015 of this division (relating to What qualifications must the director of my child-care center licensed for 13 or more children meet?);

(2) Under (4) or (6) in Figure: 26 TAC §746.1017 of this division (relating to What qualifications must the director of my child-care center licensed for 12 or fewer children meet?); or

(3) As an interim director as outlined in §746.1067 of this division (relating to When may a child-care center designate someone as its interim director?).

§746.1065. What is an interim director?

(a) An interim director is an individual designated to serve as the director of a child-care center under §746.1067 of this division (relating to When may a child-care center designate someone as its interim director?).

(b) The interim director has the same responsibilities as a child-care center director as outlined in this chapter.

§746.1067. When may a child-care center designate someone as its interim director?

A child-care center may designate an individual to serve as its interim director if:

(1) The center is operating with an initial license; and

(2) The individual meets all the requirements to serve as director except the educational requirement in:

(A) §746.1015 of this division (relating to relating to What qualifications must the director of my child-care center licensed for 13 or more children meet?); or

(B) §746.1017 of this division (relating to What qualifications must the director of my child-care center licensed for 12 or fewer children meet?).

§746.1069. May someone serving as interim director of a child-care center continue to serve as director after the center receives a full license?

(a) Someone serving as interim director of a child-care center may serve as the center's director after the center receives a full license if:

(1) The individual has completed the educational requirement and fully qualifies to serve as a child-care center director; or

(2) The child-care center obtains a waiver or variance from Child Care Regulation that allows the center to have a director who does not meet the educational requirement.

(b) A child-care center must employ a new director if the individual who served as interim director does not qualify under subsection (a) of this section.

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

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TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 127. DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS

SUBCHAPTER A. DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS

28 TAC §127.1, §127.25

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §127.1, concerning designated doctor (DD) examination requests and §127.25, concerning failure to attend a DD examination.

The amendments to §127.1 and §127.25 are adopted without changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3909). Section 127.1 and §127.25 will not be republished.

REASONED JUSTIFICATION. The amendments to 28 TAC §127.1 and §127.25 are necessary to implement House Bill (HB) 2468, 88th Legislature, Regular Session (2023). HB 2468 amended Texas Labor Code §408.0041 to include individuals receiving lifetime income benefits under new Labor Code §408.1615. Section 408.1615 allows insurance carriers to suspend benefits if the first responder does not submit to a DD examination as required by Labor Code §§408.0041(a), 408.0041(f), or 408.1615(h). DWC amends 28 TAC §127.1 and §127.5 to reflect these statutory changes.

Section 127.1 concerns requesting DD examinations. The injured employee or an insurance carrier may ask DWC to order, or DWC on its own motion may order, an examination by a DD to resolve questions about the employee's injury. Section 127.1(d)(2) states that DWC will deny a request for a DD examination under §127.1 if the request would require a DD examination that violates certain statutes. The amendment to §127.1(d)(2) adds a reference to Labor Code §408.1615 as one of these statutes because HB 2468 amended §408.0041 to include individuals receiving lifetime income benefits under §408.1615.

Section 127.25 concerns the suspension, reinitiation, and reinstatement of benefits when an injured employee fails to attend a DD examination. Amending §127.25 is necessary to implement HB 2468. HB 2468 amended Labor Code §408.0041 to include individuals receiving lifetime income benefits under new Labor Code §408.1615. The adopted amendments to §127.25 allow for the suspension of lifetime benefits received under §408.1615 and for the reinstatement of those benefits after completing a missed DD examination.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received one written comment, and no oral comments. Commenters in support of the proposal with changes were: Texas Mutual Insurance Company (TMIC). There were no commenters were against the proposal.

Comment on §127.1. TMIC recommended providing guidance in the rule to DDs and other system participants regarding the specific information that system participants should provide when requesting a DD examination to address initial lifetime income benefits versus ongoing eligibility for lifetime income benefits under proposed §127.1(b)(8).

Agency Response to Comment on §127.1. DWC declines to make changes to the rule to require certain information from system participants or provide guidance to DDs regarding the assessment of initial lifetime income benefits versus ongoing eligibility for lifetime income benefits because DWC's robust training and outreach programs for DDs make additional educational rule amendments unnecessary. DWC will continue to provide active outreach and guidance on this issue.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §127.1 and §127.25 under Labor Code §§408.0041, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD examination to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD examination, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

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

Filed with the Office of the Secretary of State on November 1, 2024.

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CHAPTER 131. BENEFITS--LIFETIME INCOME BENEFITS

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §131.1, concerning the initiation of and request to receive lifetime income benefits, the restructuring of §§131.1 - 131.4 into new Subchapter A, new §§131.10 - 131.14, concerning lifetime income benefits for first responders under Texas Labor Code §408.1615. The amendments and new sections will restructure Chapter 131 into two subchapters. New Subchapter A will include the existing sections of Chapter 131, which are §§131.1 - 131.4. New Subchapter B will include the new sections of Chapter 131, which are §§131.10 - 131.14.

New §§131.10, 131.12, and 131.14 are adopted with changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3911) and will be republished. In response to public comment, DWC revised the definition of "first responders" to "first responder" in §131.10 to be consistent with the term used in Labor Code §408.1615, replaced the term "electronically" with "electronic transmission" in §131.12(c)(1) to maintain consistency with terminology in other rules, changed "division" to "commissioner" in proposed §131.14(b) to be consistent with the Labor Code, changed proposed §131.14(b) to state that once DWC "reviews" information from the insurance carrier versus "upon receipt" of the information, and added language to §131.12(d) that requires the insurance carrier to include on a first responder's annual certification the date by which the certification must be returned to the insurance carrier under §131.12(c).

Sections 131.1 - 131.4, 131.11, and 131.13 are adopted without changes to the proposed text published in the May 31, 2024, issue of the *Texas Register* (49 TexReg 3911) and will not be republished.

REASONED JUSTIFICATION. The amendments to §131.1 and new §§131.10 - 131.14 are necessary to implement House Bill (HB) 2468, 88th Legislature, Regular Session (2023). HB 2468 amended Labor Code §408.0041 and enacted Labor Code §408.1615, which allows certain first responders to receive lifetime income benefits.

The amendments and new sections add definitions and create procedures for a first responder's annual certification to the insurance carrier, the suspension and reinstatement of lifetime income benefits, and the dispute of a first responder's continuing entitlement to lifetime income benefits.

The amendments and new sections also include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and improve the rule's clarity.

Section 131.1 concerns the initiation of lifetime income benefits by the insurance carrier or at the request of the injured employee and provides for the approval or denial of those benefits. Amending §131.1 was necessary to implement Labor Code §408.1615. Section 408.1615 makes certain first responders eligible for lifetime income benefits. The amendments add a reference to Labor Code §408.1615 in §131.1 to include individuals who are eligible to receive lifetime income benefits under §408.1615.

Section 131.10 concerns definitions in new Labor Code §408.1615. Definitions were added to improve the rule's clarity.

Section 131.11 concerns applicability for new Subchapter B. New §131.11 is necessary to implement Labor Code §408.1615, which created lifetime income benefits for certain first responders. Section 131.11 lists who may be entitled to these benefits under §408.1615.

Section 131.12 concerns a first responder's annual certification to the insurance carrier as required by Labor Code §408.1615. New §131.12 is necessary to implement §408.1615 by listing the content, method, and timing of the certification. To help first responders comply with the certification submission required under §408.1615, new §131.12 requires insurance carriers to provide notice to those receiving benefits under §408.1615 by sending the first responder their certification to complete 30 days before the certification is due. The insurance carrier must include on the certification the anniversary date the first responder's benefits began to accrue and the date by which the first responder must return the certification to the insurance carrier.

Section 131.13 concerns the suspension and reinstatement of lifetime income benefits for first responders under Labor Code §408.1615. New §131.13 is necessary to implement Labor Code §408.1615, which states when an insurance carrier may suspend a first responder's lifetime income benefits under that section and when an insurance carrier must reinstate those benefits. Section 408.1615(i) requires the commissioner, by rule, to ensure that an employee receives reasonable notice of the insurance carrier's basis for the suspension of lifetime income benefits and is provided a reasonable opportunity to complete the annual certification or otherwise respond to the notice. DWC interprets a reasonable opportunity as being 20 days. As a result, new §131.13 requires the insurance carrier to give the first responder a plain-language notice of the basis for the suspension, and requires the first responder to respond to the notice within 20 days of receiving it, before the insurance carrier may suspend the first responder's benefits. In addition, new §131.13 states that if the suspension is due to a missing annual certification, the insurance carrier must reinstate benefits within seven days of receiving the certification. It also states that if the suspension is due to failure to attend a designated doctor (DD) examination, the insurance carrier must follow §127.25 of this title for suspension and reinstatement of the first responder's benefits. If the first responder believes that the insurance carrier's assertion that the first responder was employed is not correct, then the first responder may request dispute resolution under Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution). If the suspension is due to employment in any capacity,

new §131.13 requires the first responder to submit a new request for lifetime income benefits under §131.1. Finally, new §131.13 clarifies that if the insurance carrier suspends or reinstates benefits under §131.13, the insurance carrier must comply with the electronic notification requirements to DWC in §124.2 and Chapter 124, Subchapter B (relating to Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

Section 131.14 provides for the dispute of a first responder's continuing entitlement to lifetime income benefits. New §131.14 is necessary to implement Labor Code §408.1615, which allows an insurance carrier to review a first responder's continuing entitlement to lifetime income benefits more than once in a five-year period if the insurance carrier provides evidence to DWC that the first responder's annual certification is not accurate, and the commissioner finds that the evidence is sufficient. If the evidence is sufficient, the insurance carrier must request a DD exam to determine whether the first responder remains eligible to receive lifetime income benefits under §408.1615. New §131.14 details this process. Once the commissioner receives the evidence from an insurance carrier, the commissioner will issue an order stating whether the insurance carrier is entitled to require the first responder to submit to a DD examination under §408.1615(h). If a DD exam is completed, the parties may dispute the DD's opinion on the first responder's continuing entitlement to lifetime income benefits through DWC's dispute resolution process.

Parties may request dispute resolution. During the dispute resolution process, parties have the right to request an interlocutory order to suspend benefits or require that they continue while the dispute is pending.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received three written comments, and no oral comments. Commenters in support of the proposal with changes were: Flahive, Ogden, & Latson (FOL); Office of Injured Employee Counsel (OIEC); and Texas Mutual Insurance Company (TMIC). There were no commenters against the proposal.

General Comment on the termination of a first responder's lifetime income benefits under Labor Code §408.1615. TMIC commented that the proposed rules do not provide guidance on terminating a first responder's lifetime income benefits under Labor Code §408.1615.

Agency Response to Comment. DWC appreciates the comment but declines to make the suggested change. Section 131.14(c) and (d) provide parties with the ability to seek dispute resolution regarding continual entitlement to lifetime income benefits, including the ability to dispute a DD's opinion on this issue. In the dispute resolution process, parties may seek a final decision on the issue of continuing entitlement to lifetime income benefits.

Comment on §131.10. OIEC commented that they support DWC's removal of the definition of "permanently unemployable."

Agency Response to Comment on §131.10. DWC appreciates the comment.

Comment on §131.10. TMIC suggested that DWC consider revising the definition of "first responders" to "first responder" in §131.10 to be consistent with the term used in Labor Code §408.1615.

Agency Response to Comment on §131.10. DWC appreciates and agrees with the suggestion and has revised the defined term to read "first responder."

Comment on §131.12(c)(1). TMIC recommended replacing the term "electronically" with the term "electronic transmission" in §131.12(c)(1) to maintain consistency with terminology in other rules.

Agency Response to Comment on §131.12(c)(1). DWC appreciates the comment and has replaced the term.

Comment on §131.14. FOL commented that, under proposed §131.14(b), the "division" will issue an order stating whether the insurance carrier is entitled to an examination under §408.1615(h). However, under the Labor Code, only the "commissioner" may issue an order or delegate that authority to a designee. There is no authority to delegate the authority to the agency itself.

Agency Response to Comment on §131.14. DWC appreciates the comment and has changed "division" to "commissioner" in §131.14(b).

Comment on §131.12(b). TMIC suggested that DWC revise §131.12(b) to clarify what information is required on a first responder's annual certification to the insurance carrier when the first responder is not working in any capacity. TMIC also suggested permitting an insurance carrier to issue a notice in circumstances where the first responder submits an incomplete certification. TMIC also recommended that, if the first responder does not respond to the notice after 30 days, the insurance carrier be permitted to suspend lifetime income benefits after 30 days and request a DD examination to determine a first responder's ongoing eligibility for these benefits.

Agency Response to Comment on §131.12(b). DWC declines to make the suggested changes. The requirement for the annual certification is a simple, straightforward statement that is either submitted or not. DWC will provide active outreach to first responders to help guide them on the certification and its process. Also, DWC has adopted procedural rules that provide guidance on submitting the annual certification. Labor Code §408.1615 already addresses when an insurance carrier may suspend lifetime income benefits and when an insurance carrier may request a DD exam to determine a first responder's ongoing eligibility for these benefits. Adding additional rules based on an incomplete certification is unnecessary.

Comment on §131.12(c)(2) and (d). As proposed, §131.12(d) requires the insurance carrier to send the certification form to a first responder 30 days before their annual certification is due. Under §131.12(c)(2), a first responder must then submit the certification to the insurance carrier no later than 30 days after the anniversary of the lifetime income benefits accrual date. TMIC commented that the rule appears to reference the same 30-day response date in two different subsections, leading to confusion about whether there are two 30-day periods. TMIC recommended changing the timeframe that the insurance carrier must send the annual certification to the first responder from 30 days to no later than the anniversary date of when the first responder's benefits began to accrue.

Agency Response to Comment on §131.12(c)(2) and (d). DWC declines to make the suggested change. There are two 30-day periods that exist in §131.12, and each is clearly laid out in two different subsections with different titles. Section 131.12(c)(2) states that the first responder must submit the certification to the

insurance carrier no later than 30 days after the date the first responder's benefits began to accrue. Section 131.12(d) requires the insurance carrier to send the first responder the certification to complete 30 days before it is due. Requiring insurance carriers to send the certification to the first responder 30 days before it is due will give first responders notice that they must complete the certification and allows them sufficient time to read, understand, and complete the certification.

Comment on §131.12. OIEC commented that they support the rule requiring an insurance carrier to provide the annual certification to the first responder 30 days before the annual certification is due.

Agency Response to Comment on §131.12. DWC appreciates the comment.

Comment on §131.12(d). TMIC recommended adding language to §131.12(d) that requires the insurance carrier to include on a first responder's annual certification the date the certification must be returned to the insurance carrier under §131.12(c).

Agency Response to Comment on §131.12(d). DWC appreciates the comment and has revised the text to require insurance carriers to include on the certification the date the first responder must return the certification to the insurance carrier.

Comment on §131.13. TMIC recommended that §131.13(c) be revised to clarify that the insurance carrier must reinstate benefits, unless the completed annual certification indicates that the first responder was employed in some capacity during the preceding year, and that the insurance carrier has the right to dispute ongoing entitlement under §131.14.

Agency Response to Comment on §131.13. DWC declines to make the recommended changes. Section 131.13(a) follows Labor Code §408.1615(i), stating that an insurance carrier may suspend lifetime income benefits to a first responder during and for a period in which the first responder fails to complete the annual certification as required by Labor Code §408.1615(e). Section 408.1615(e) requires a first responder receiving lifetime income benefits under §408.1615 to certify to the insurance carrier annually that the first responder was not employed in any capacity during the preceding year. If the first responder was employed in any capacity, §131.13(a)(3) allows the insurance carrier to suspend the payment of lifetime income benefits. Also, §131.13(e) states that, if an insurance carrier suspends benefits under §131.13(a)(3), the first responder must submit a new request for lifetime income benefits under §131.1. As a result, the statute and rules already address the scenario when a completed annual certification indicates that the first responder was employed in some capacity during the preceding year.

Comment on §131.14. FOL suggested that DWC provide the standard it will use to determine if the first responder's annual certification is not accurate. FOL further suggested that the commissioner's order should contain specific findings of facts explaining why the request was denied if it is denied.

Agency Response to Comment on §131.14. DWC declines to make the suggested changes because they are unnecessary and not required by the statute. Labor Code §408.1615(g) states the commissioner will decide if the information contained on the annual certification "may not be accurate." If the insurance carrier disagrees with that determination, it may request dispute resolution. As part of the dispute resolution process, an insurance carrier may request an interlocutory order. DWC declines to adopt a requirement that the commissioner provide specific findings of fact on the order due to the lack of statutory basis for such a requirement in Labor Code §408.1615.

Comment on §131.13. OIEC commented that they support the change in time that a first responder must respond to an insurance carrier before the insurance carrier may suspend lifetime income benefits under §131.13(a) from 30 days to 20 days.

Agency Response to Comment on §131.13. DWC appreciates the comment.

Comment on §131.13. TMIC recommended removing the requirement in §131.13(b) that insurance carriers must send a notice to the first responder if the first responder has not turned in their annual certification, allowing the first responder 20 days to respond before suspending lifetime income benefits under §131.13. TMIC stated that the 20-day notice is inconsistent with Labor Code §408.1615.

Agency Response to Comment on §131.13. DWC declines to make the suggested changes. Labor Code §408.1615(i) states that a first responder's lifetime income benefits may be suspended under certain circumstances. Section 408.1615(i) requires the commissioner to adopt rules that ensure that a first responder receives reasonable notice of the insurance carrier's basis for the suspension and is provided a reasonable opportunity to complete the annual certification under subsection (e), or otherwise respond to the notice. The Labor Code allows suspension under certain circumstances under §408.1615, but it also requires the commissioner to adopt rules that ensure a first responder is allowed a reasonable opportunity to respond. A "reasonable opportunity" to respond to the notice means that the first responder is allowed time to respond by completing their annual certification *before* an insurance carrier may suspend their lifetime income benefits. The people receiving benefits under this rule are first responders who have sustained serious injuries. Giving them 20 days' notice before an insurance carrier may suspend lifetime income benefits is appropriate and aligns with the requirements under Labor Code §408.1615(i).

Comment on §131.13. TMIC recommended that §131.13 be revised to clarify that an insurance carrier may suspend lifetime income benefits immediately in conjunction with a DD opinion concluding that the first responder is no longer eligible for lifetime income benefits. They commented that this change would follow the precedent in §127.25 and Labor Code §408.0041(e) that a DD's report has presumptive weight on the issue that was assigned to the DD, unless the report is overturned during the dispute resolution process. Under this recommendation, if a first responder successfully disputes the DD report, then the dispute decision can order lifetime income benefits to be reinstated, similar to how all other income benefit disputes are generally handled. Likewise, if the first responder's dispute of the DD report is not successful, then lifetime income benefits are terminated until a first responder meets the eligibility requirements again at a later date.

Agency Response to Comment on §131.13. DWC declines to make the recommended changes. Labor Code §408.0041(j) states that an employee is not entitled to lifetime income benefits under §408.1615, and an insurance carrier is authorized to suspend the payment of those benefits, during and for a period in which the employee fails to submit to a DD examination required by §408.0041(a) or (f) or, if applicable, §408.1615(h), unless the commissioner determines that the employee had good cause for failing to submit to the examination. Section 408.0041(j) also states that the commissioner, by rule, must ensure that the em-

ployee receives reasonable notice of the insurance carrier's basis for suspension and that the employee is provided a reasonable opportunity to reschedule a DD examination for good cause. Further, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure that an employee receives reasonable notice of the insurance carrier's basis for suspension and is provided a reasonable opportunity to respond to the notice. Twenty days is a reasonable opportunity to allow the first responder to respond by rescheduling their DD examination *before* an insurance carrier may suspend benefits. As a result, giving first responders 20 days' notice before an insurance carrier may suspend benefits is appropriate and aligns with the commissioner's requirements under Labor Code §408.1615(i).

Section 131.13(b) does not conflict with §127.25 and §131.13(d) because requiring notice does not change any of those sections' provisions or impair how they function. Section 131.13(d) states that, if an insurance carrier suspends benefits because the first responder fails to attend a DD examination without good cause, the insurance carrier must follow §127.25 for suspension and reinstatement of the first responder's benefits. Section 127.25 allows an insurance carrier to suspend lifetime income benefits if a first responder fails, without good cause, to attend a DD examination. Neither §127.25 nor §131.13(d) disallow the first responder to receive notice by the insurance carrier and to respond to the insurance carrier. Requiring notice and an opportunity to respond simply ensures that the injured first responder's benefits are not needlessly and unjustly interrupted. As a result, requiring insurance carriers to send a first responder 20 days' notice to allow the first responder to reschedule a DD examination under §131.13(b) does not conflict with §131.13(d) and §127.25.

DWC declines to make TMIC's suggested change that §131.13 be revised to clarify that an insurance carrier may suspend lifetime income benefits immediately in conjunction with a DD opinion concluding that the first responder is no longer eligible for lifetime income benefits. As with reasonable notice before suspending a first responder's lifetime income benefits for submitting a late annual certification or rescheduling a missed DD exam, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure a first responder receives reasonable notice of an insurance carrier's basis for suspension and be provided a reasonable opportunity to respond to the notice. Adopted §131.13 provides the first responder a timeframe to have a reasonable opportunity to respond to the notice before an insurance carrier may suspend lifetime income benefits.

Comment on §131.13. FOL commented that the proposed 20-day notice requirement in §131.13(b)(2) prevents a political subdivision from suspending lifetime income benefits immediately. Further, if the injured employee notifies the insurance carrier of the DD exam or simply requests a benefit review conference, the political subdivision must continue to pay benefits. FOL commented that this exceeds the statute, as notice is not a precondition for suspension. FOL stated that continued payments without entitlement results in unjustified payments, violating constitutional limits on public funds, when the "carrier" is a self-insured political subdivision or state agency.

Agency Response to Comment on §131.13. DWC declines to make the suggested changes. A political subdivision or state agency that is self-insuring its workers' compensation liabilities is acting as a workers' compensation insurance carrier and must comply with the workers' compensation statutes and rules. Labor Code §408.0041(j) requires the commissioner, by rule, to ensure that the first responder receives reasonable notice of the insurance carrier's basis for suspension and that the employee be provided a reasonable opportunity to reschedule a DD examination for good cause. Further, Labor Code §408.1615(i) requires the commissioner to adopt rules that ensure a first responder receives reasonable notice of the insurance carrier's basis for suspension and be provided a reasonable opportunity to respond to the notice under all scenarios in which a first responder's lifetime income benefits may be suspended under §408.1615(i). A "reasonable opportunity" to respond to the notice is one that gives the first responder time to respond *before* an insurance carrier may suspend benefits. As a result, giving first responders 20 days' notice before an insurance carrier may suspend lifetime income benefits is appropriate and aligns with the commissioner's requirements under Labor Code §408.1615(i).

Comment on §131.14. TMIC suggested that DWC recognize the insurance carrier's ability to request a DD examination to evaluate a first responder's ongoing eligibility for lifetime income benefits at least every five years, as well as those circumstances where a first responder has failed to submit the annual certification and lifetime income benefits have been suspended.

Agency Response to Comment on §131.14. DWC declines to make the suggested changes. Labor Code §408.1615(f) states that an insurance carrier may periodically review a first responder's continuing entitlement to lifetime income benefits no more than once during any five-year period, subject to the exception contained in Labor Code §408.1615(g) regarding an annual certification that may not be accurate. Because the insurance carrier's ability to request a DD examination is specified in the Labor Code, DWC declines to duplicate that authority in the rules.

Labor Code §408.1615(f) and (g) do not mention a situation where a first responder does not submit a timely annual certification. DWC disagrees that Labor Code §408.1615 permits an insurance carrier to request a DD examination before the five-year time period in Labor Code §408.1615(f) if the first responder does not timely submit the annual certification.

Comment on §131.14. FOL commented that it's not clear if the insurance carrier must continue to pay lifetime income benefits if the insurance carrier requests a DD appointment prior to five years, that request is denied, and it seeks dispute resolution to dispute that denial.

Agency Response to Comment on §131.14. DWC declines to add to the rule text to address an issue that is already clear in the statute. Labor Code §408.0041(f) states that, unless otherwise ordered by the commissioner, the insurance carrier must pay benefits based on the opinion of the DD during the pendency of any dispute. If the most recent DD examination on the issue of entitlement to lifetime benefits has found that the first responder meets the requirements for qualification, the insurance carrier must pay benefits during the pendency of any dispute.

Comment on §131.13. OIEC asked DWC to reconsider adding a good cause exception to an insurance carrier's ability to suspend lifetime income benefits found in proposed Rule 131.13. OIEC commented that DWC provides a good cause exception for failing to attend a DD examination in Rule 131.13(a)(2) because Labor Code §408.1615(i) requires DWC to consider a good cause exception for any statutorily mentioned scenario for suspension. OIEC suggested that the word "unless" in the statute modifies any of the preceding list of scenarios, not only failing to attend a DD examination. OIEC suggested adding new Rule 131.13(b) as follows: (b) The insurance carrier may not suspend lifetime in-

come benefits if the commissioner determines that there is good cause.

Agency Response to Comment on §131.13. DWC appreciates the comment but declines to make the suggested change. Under Labor Code §408.1615(i), the good cause exception only applies to §408.0041(j), where a first responder fails to submit to a DD examination under §408.0041(a) or (f) or §408.1615(h), and to §408.0041(k-1) where a DD report indicates that the first responder is no longer entitled to lifetime income benefits. If DWC applied the good cause exception to each scenario under which suspension could occur in §408.1615(i), DWC would have to apply the good cause exception for situations where the first responder has worked in some capacity, which is incompatible with the rest of the language in the statute, particularly with the wording "permanently unemployable."

Comment on §131.14. OIEC commented that it supports DWC's inclusion of a dispute resolution option for parties who disagree with DWC's order regarding whether an insurance carrier is entitled to request an examination under Labor Code §408.1615(h).

Agency Response to Comment on §131.14. DWC appreciates the comment.

General Comment on Rule Guidance and Training Addressing a Physically Traumatic Injury to the Brain. OIEC commented that they would like DWC to create rules addressing a physically traumatic injury to the brain in §408.161(a)(6). OIEC recommended rules and training for DDs to determine whether a physically traumatic injury to the brain results in a permanent major neurocognitive disorder, whether the injured employee requires occasional supervision in performing daily tasks or self-care, and whether the injured employee is permanently unemployable. OIEC also recommended that the rule clarify that the DD is qualified to render those opinions. Alternatively, if the DD is not competent to render those decisions, OIEC commented that the training should include guidance for the DD to refer the matter to qualified occupational specialists or others for necessary opinions.

Agency Response to Comment. DWC declines to make the requested changes because they are out of scope of this rule. In addition, DWC's rules already address qualifications for DDs to evaluate traumatic brain injuries, including the ability to refer those injuries to specialists when necessary. Also, DWC already provides in-depth training for DDs in performing their duties.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §§131.1

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts new Subchapter A, Chapter 131; amendments to §131.1; and relocating §§131.1 - 131.4 under Subchapter A under Labor Code §§408.0041, 408.161, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD exam to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD exam, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.161 provides lifetime income benefits for certain injuries.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

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

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405236
Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: November 21, 2024
Proposal publication date: May 31, 2024
For further information, please call: (512) 804-4703

SUBCHAPTER B. LIFETIME INCOME BENEFITS--CERTAIN FIRST RESPONDERS

28 TAC §§131.10 - 131.14

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts new §§131.10 - 131.14 under Labor Code §§408.0041, 408.1615, 402.00111, 402.00116, and 402.061.

Labor Code §408.0041 provides that the commissioner may order a DD exam to resolve questions about an individual's injuries. It also provides that an insurance carrier may suspend benefits for a period in which the individual does not attend the required DD exam, and provides for when the insurance carrier must reinstate benefits.

Labor Code §408.1615 provides lifetime income benefits for certain first responders who sustain a serious bodily injury, other than an injury described by §408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§131.10. Definitions.

In Subchapter B of this chapter:

(1) "First responder" means "first responder" as defined in Labor Code §408.1615.

(2) "Serious bodily injury" means "serious bodily injury" as defined in Penal Code §1.07.

§131.12. First Responder's Annual Certification to Insurance Carrier.

(a) Requirement. A first responder receiving lifetime income benefits under §408.1615 must file a certification with the insurance carrier annually.

(b) Content. The certification must state that the first responder was not employed in any capacity during the preceding year.

(c) Method and Timing. The first responder must submit the certification to the insurance carrier in the form and manner prescribed by the division:

(1) by first class mail, by personal delivery, or by electronic transmission; and

(2) no later than 30 days after the anniversary of the date the first responder's lifetime income benefits began to accrue.

(d) Notice. Every year, 30 days before the first responder's annual certification is due, an insurance carrier must send the annual certification to complete to the first responder. The certification must include the anniversary date the first responder's lifetime income benefits began to accrue and the date by which the first responder must return the certification to the insurance carrier.

§131.14. Dispute of Continuing Entitlement of Lifetime Income Benefits.

(a) If the insurance carrier disputes the accuracy of the first responder's annual certification under Labor Code §408.1615(g), the insurance carrier must provide a copy of the annual certification along with supporting evidence to the commissioner and to the first responder.

(b) Upon review of the information in subsection (a) of this section, the commissioner will issue an order stating whether the insurance carrier is entitled to an examination under Labor Code §408.1615(h).

(c) The parties may dispute the determination of the division through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

(d) After receiving the designated doctor's report under Labor Code §408.1615(h), a party may dispute the designated doctor's opinion on continuing entitlement to lifetime income benefits through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

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

Filed with the Office of the Secretary of State on November 1, 2024.

TRD-202405237
Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: November 21, 2024
Proposal publication date: May 31, 2024
For further information, please call: (512) 804-4703

Texas

TRANSFERRED RULES

The Government Code, §2002.058, authorizes the Secretary of State to remove or transfer rules within the Texas Administrative Code when the agency that promulgated the rules is abolished. The Secretary of State will publish notice of rule transfer or removal in this section of the *Texas Register*. The effective date of a rule transfer is the date set by the legislature, not the date of publication of notice. Proposed or emergency rules are not subject to administrative transfer.

Department of State Health Services

Rule Transfer

During the 84th Legislative Session, the Texas Legislature passed Senate Bill 200, addressing the reorganization of health and human services delivery in Texas. As a result, certain functions previously performed by the Department of State Health Services (DSHS), including client services, certain regulatory functions, and the operation of state hospitals, transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code, §531.0201 and §531.02011. The DSHS rules in Texas Administrative Code, Title 25, Part 1, Chapter 31, Nutrition Services, Subchapter C, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), that are related to these transferred functions, are being transferred to HHSC under Texas Administrative Code, Title 26, Part 1, Chapter 366, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The rules will be transferred in the Texas Administrative Code effective December 13, 2024.

The following table outlines the rule transfer:

Figure: 25 TAC Chapter 31, Subchapter C

TRD-202405239

Health and Human Services Commission

Rule Transfer

During the 84th Legislative Session, the Texas Legislature passed Senate Bill 200, addressing the reorganization of health and human services delivery in Texas. As a result, certain functions previously performed by the Department of State Health Services (DSHS), including client services, certain regulatory functions, and the operation of state hospitals, transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code, §531.0201 and §531.02011. The DSHS rules in Texas Administrative Code, Title 25, Part 1, Chapter 31, Nutrition Services, Subchapter C, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), that are related to these transferred functions, are being transferred to HHSC under Texas Administrative Code, Title 26, Part 1, Chapter 366, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The rules will be transferred in the Texas Administrative Code effective December 13, 2024.

The following table outlines the rule transfer:

Figure: 25 TAC Chapter 31, Subchapter C

TRD-202405241

Figure: 25 TAC Chapter 31, Subchapter C

Current Rules Title 25. Health Services Part 1. Department of State Health Services Chapter 31. Nutrition Services Subchapter C. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	**Move to Title 26. Health and Human Services Part 1. Health and Human Services Commission Chapter 366. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**
§31.21. Definitions.	§366.1. Definitions.
§31.22. Recipient Eligibility Requirements.	§366.3. Recipient Eligibility Requirements.
§31.23. Recipients of Supplemental Food Benefits.	§366.5. Recipients of Supplemental Food Benefits.
§31.25. Participant Certification Periods.	§366.7. Participant Certification Periods.
§31.26. Notification to Applicants of Ineligibility.	§366.9. Notification to Applicants of Ineligibility.
§31.27. Notification to Each Participant of Certification Expiration.	§366.11. Notification to Each Participant of Certification Expiration.
§31.28. Notification to Each Participant of Termination of Certification.	§366.13. Notification to Each Participant of Termination of Certification.
§31.29. Applicant and Participant Rights.	§366.15. Applicant and Participant Rights.
§31.30. Participant Fraud and Abuse.	§366.17. Participant Fraud and Abuse.
§31.31. Selection of a Local Agency as a WIC Provider.	§366.19. Selection of a Local Agency as a WIC Provider.
§31.37. Selection of Allowable WIC Program Supplemental Foods.	§366.21. Selection of Allowable WIC Program Supplemental Foods.

Department of State Health Services

Rule Transfer

During the 84th Legislative Session, the Texas Legislature passed Senate Bill 200, addressing the reorganization of health and human services delivery in Texas. As a result, certain functions previously performed by the Department of State Health Services (DSHS), including client services, certain regulatory functions, and the operation of state hospitals, transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code, §531.0201 and §531.02011. The DSHS rules in Texas Administrative Code, Title 25, Part 1, Chapter 415, Provider Clinical Responsibilities--Mental Health Services, Subchapter F, Interventions in Mental Health Services, that are related to these transferred functions, are being transferred to HHSC under Texas Administrative Code, Title 26, Part 1, Chapter 320, Rights of Individuals, Subchapter C, Interventions in Mental Health Services.

The rules will be transferred in the Texas Administrative Code effective December 13, 2024.

The following table outlines the rule transfer:

Figure: 25 TAC Chapter 415, Subchapter F

TRD-202405242

Health and Human Services Commission

Rule Transfer

During the 84th Legislative Session, the Texas Legislature passed Senate Bill 200, addressing the reorganization of health and human services delivery in Texas. As a result, certain functions previously performed by the Department of State Health Services (DSHS), including client services, certain regulatory functions, and the operation of state hospitals, transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code, §531.0201 and §531.02011. The DSHS rules in Texas Administrative Code, Title 25, Part 1, Chapter 415, Provider Clinical Responsibilities--Mental Health Services, Subchapter F, Interventions in Mental Health Services, that are related to these transferred functions, are being transferred to HHSC under Texas Administrative Code, Title 26, Part 1, Chapter 320, Rights of Individuals, Subchapter C, Interventions in Mental Health Services.

The rules will be transferred in the Texas Administrative Code effective December 13, 2024.

The following table outlines the rule transfer:

Figure: 25 TAC Chapter 415, Subchapter F

TRD-202405243

Figure: 25 TAC Chapter 415, Subchapter F

Current Rules Title 25. Health Services Part 1. Department of State Health Services Chapter 415. Provider Clinical Responsibilities--Mental Health Services Subchapter F. Interventions in Mental Health Services	**Move to Title 26. Health and Human Services Part 1. Health and Human Services Commission Chapter 320. Rights of Individuals Subchapter C. Interventions in Mental Health Services**
§415.251. Purpose.	§320.101. Purpose.
§415.252. Application.	§320.103. Application.
§415.253. Definitions.	§320.105. Definitions.
§415.254. General Requirements for Use of Restraint or Seclusion.	§320.107. General Requirements for Use of Restraint or Seclusion.
§415.255. Prohibited and Restricted Practices.	§320.109. Prohibited and Restricted Practices.
§415.256. Mechanical Restraint Devices.	§320.111. Mechanical Restraint Devices.
§415.257. Staff Member Training.	§320.113. Staff Member Training.
§415.258. Actions to be Taken to Release from Restraint or Seclusion for an Emergency Medical Condition or Evacuation Emergency.	§320.115. Actions to be Taken to Release from Restraint or Seclusion for an Emergency Medical Condition or Evacuation Emergency.
§415.259. Special Considerations, Responsibilities, and Alternative Strategies.	§320.117. Special Considerations, Responsibilities, and Alternative Strategies.
§415.260. Initiation of Restraint or Seclusion in a Behavioral Emergency.	§320.119. Initiation of Restraint or Seclusion in a Behavioral Emergency.
§415.261. Time Limitation on an Order for Restraint or Seclusion Initiated in Response to a Behavioral Emergency.	§320.121. Time Limitation on an Order for Restraint or Seclusion Initiated in Response to a Behavioral Emergency.
§415.262. Family Notification.	§320.123. Family Notification.
§415.263. Safekeeping of Personal Possessions During Mechanical Restraint or Seclusion.	§320.125. Safekeeping of Personal Possessions During Mechanical Restraint or Seclusion.
§415.264. Restraint Off Facility Premises or for Transportation.	§320.127. Restraint Off Facility Premises or for Transportation.
§415.265. Communicating with the Individual During Restraint or Seclusion Initiated in Response to a Behavioral Emergency.	§320.129. Communicating with the Individual During Restraint or Seclusion Initiated in Response to a Behavioral Emergency.
§415.266. Observation, Monitoring, and Care of the Individual in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.	§320.131. Observation, Monitoring, and Care of the Individual in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.
§415.267. Safe and Appropriate Techniques for Restraint or Seclusion.	§320.133. Safe and Appropriate Techniques for Restraint or Seclusion.
§415.268. Actions to be Taken when an Individual Falls Asleep in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.	§320.135. Actions to be Taken when an Individual Falls Asleep in Restraint or Seclusion Initiated in Response to a Behavioral Emergency.

§415.269. Transfer of Primary Responsibility for Individual in Restraint or Seclusion.	§320.137. Transfer of Primary Responsibility for Individual in Restraint or Seclusion.
§415.270. Release of an Individual From Restraint or Seclusion.	§320.139. Release of an Individual From Restraint or Seclusion.
§415.271. Actions to be Taken Following Release of an Individual from Restraint or Seclusion Initiated in Response to a Behavioral Emergency.	§320.141. Actions to be Taken Following Release of an Individual from Restraint or Seclusion Initiated in Response to a Behavioral Emergency.
§415.272. Documenting, Reporting, and Analyzing Restraint or Seclusion.	§320.143. Documenting, Reporting, and Analyzing Restraint or Seclusion.
§415.273. Use of Restraint in Situations Involving Non-violent, Non-self-destructive Behavior.	§320.145. Use of Restraint in Situations Involving Non-violent, Non-self-destructive Behavior.
§415.274. Permitted Practices.	§320.147. Permitted Practices.
§415.275. Clinical Timeout and Quiet Time.	§320.149. Clinical Timeout and Quiet Time.
§415.276. Protective and Supportive Devices.	§320.151. Protective and Supportive Devices.

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Review Of Agency Rules

This section contains notices of state agency rule review as directed by the Texas Government Code, §2001.039. Included here are proposed rule review notices, which invite public comment to specified rules under review; and adopted rule review notices, which summarize public comment received as part of the review. The complete text of an agency's rule being reviewed is available in the *Texas Administrative Code* on the Texas Secretary of State's website.

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the website and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Reviews

Texas Health and Human Services Commission

Title 26, Part 1

The Texas Health and Human Services Commission (HHSC) adopts the review of the chapter below in Title 26, Part 1, of the Texas Administrative Code (TAC):

Chapter 211, Day Activity and Health Services (DAHS) Contractual Requirements

Notice of the review of this chapter was published in the August 9, 2024, issue of the *Texas Register* (49 TexReg 6031). HHSC received no comments concerning this chapter.

The agency determined that the original reasons for adopting all rules in the chapter continue to exist and readopts Chapter 211. Any amendments, if applicable, to Chapter 211 identified by HHSC in the rule review will be proposed in a future issue of the *Texas Register*.

This concludes HHSC's review of 26 TAC Chapter 211 as required by the Texas Government Code §2001.039.

TRD-202405175
Jessica Miller
Director, Rules Coordination Office
Texas Health and Human Services Commission
Filed: October 30, 2024

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The Texas Health and Human Services Commission (HHSC) adopts the review of the chapter below in Title 26, Part 1, of the Texas Administrative Code (TAC):

Chapter 280, Pediatric Teleconnectivity Resource Program for Rural Texas

Notice of the review of this chapter was published in the September 20, 2024, issue of the *Texas Register* (49 TexReg 7645). HHSC received no comments concerning this chapter.

The agency determined that the original reasons for adopting rules in the chapter do not continue to exist and the repeal of Chapter 280 identified by HHSC in the rule review will be proposed in a future issue of the *Texas Register.*

This concludes HHSC's review of 26 TAC 280 as required by Texas Government Code §2001.039.

TRD-202405309
Jessica Miller
Director, Rules Coordination Office
Texas Health and Human Services Commission
Filed: November 4, 2024

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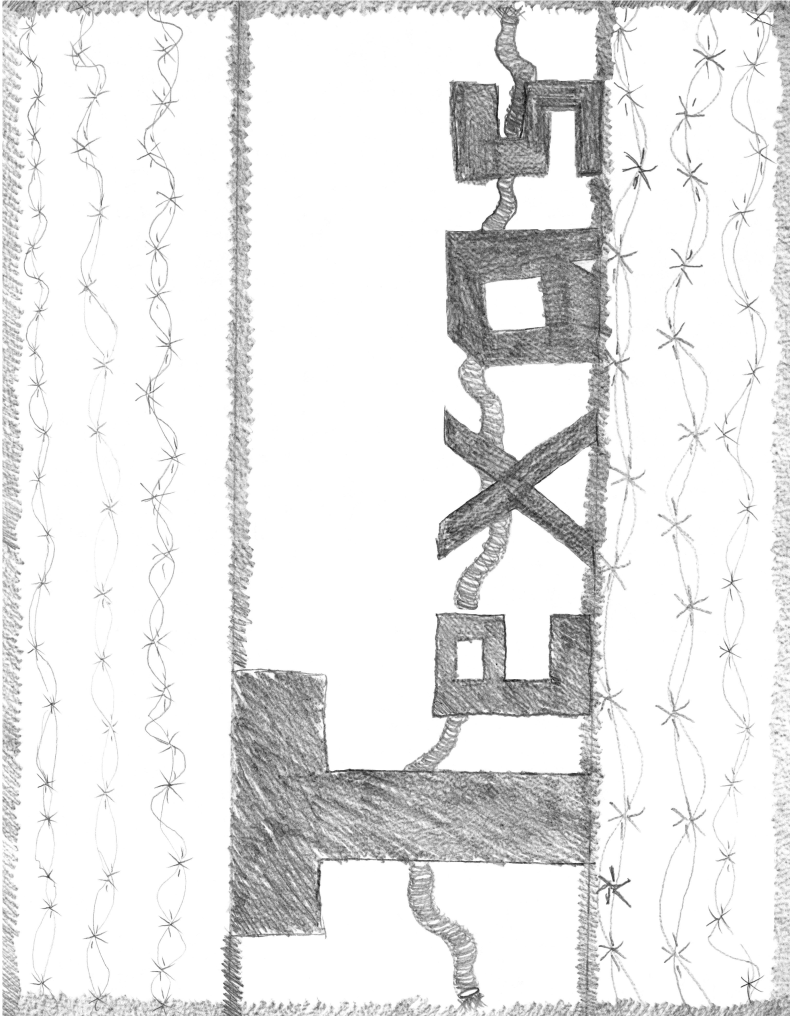
TEXAS

TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 16 TAC §402.411(d) [~~16 TAC §402.411(e)~~]

Number of Days Late	Percentage of Estimated License Fee
1-14	10%
15-28	20%
29-42	30%
43-56	40%
57-60	50%

Figure: 16 TAC §402.706(c)

Standard Administrative Penalty Chart

Category 1

$250 [~~$0 (Warning)~~] to $1,000 for the 1st offense, except a 1st offense for Violation No. 6 involving gambling devices may result in up to $1000 administrative penalty and/or license suspension, revocation or denial, or registry removal or denial

$250 [~~$0 (Warning)~~] to $1,000 and/or license suspension, revocation or denial, or registry removal or denial for the 2nd offense

No.	Violation
1	A person knowingly participated in the award of a prize to a bingo player in a manner that disregarded the random selection of numbers or symbols.
2	A person made a false statement in an application for a license.
3	A person falsified or made false entries in books and records.
4	A person conducted, promoted, or administered bingo without a license.
5	The licensee or a person designated as an agent for a unit failed to timely produce for inspection or audit any book, record, document, or other form of information requested by the Commission.
6	A person conducted or allowed a game of chance at a bingo premises during a bingo occasion, except as permitted under Occupations Code §2001.416 and 16 TAC §402.211.

Category 2

$100 [~~$0 (Warning)~~] to $600 for the 1st offense

$100 [~~$0 (Warning)~~] to $800 for the 2nd offense

$100 [~~$0 (Warning)~~] to $1,000 and/or license suspension, revocation or denial, or registry removal or denial for the 3rd offense

No.	Violation
7	The organization conducted bingo outside of the licensed time.
8	The organization sold bingo cards, bingo card minders, or pull-tab bingo tickets at an unauthorized time.
9	The organization conducted bingo at an unauthorized location.
10	The organization that is a member of a unit did not conduct its bingo games separately from the bingo games of the other members of the unit.
11	The unit with an agent designated under Section 2001.438(b) failed to immediately notify the Commission of any change in the designated agent.
12	The organization allowed a person other than a bona fide member of the licensed authorized organization to conduct, promote, or administer, or assist in conducting, promoting, or administering, bingo.
13	The organization failed to have an authorized operator present at the bingo occasion.
14	A person not listed on the registry of approved bingo workers acted as an operator, manager, cashier, usher, caller, or salesperson for an organization.
15	The organization allowed a person(s) under the age of 18 to conduct or assist in the conduct of bingo.
16	The organization or unit failed to comply with the charitable distribution requirement.
17	The organization obtained by purchase or other manner bingo equipment, devices or supplies from a person other than a licensed distributor (except as provided in Section 2001.257(b).

Category 3

$0 (Warning) to $400 for the 1st offense

$100 [~~$0 (Warning)~~] to $600 for the 2nd offense

$100 [~~$0 (Warning)~~] to $800 for the 3rd offense (Violation Nos. 18, 22, 23 – 28)

$100 [~~$0 (Warning)~~] to $1,000 and/or license suspension, revocation or denial, or registry removal or denial for the 3rd offense (Violation Nos. 19, 20, 21, & 24)

No.	Violation
18	The licensee failed to report to the Commission in writing within ten (10) working days of the date of any change respecting any facts set forth in the application.
19	The licensee failed to respond, or timely respond, in writing to all relevant audit findings and recommendations in the draft audit report presented at the exit conference.
20	The organization failed to withhold prize fees.
21	The organization or unit failed to deposit in the bingo account all funds derived from the conduct of bingo, less the amount awarded as cash prizes.
22	The organization incurred or paid items of expense in connection with the conduct of a game of bingo that were not reasonable or necessary to conduct bingo.
23	Proceeds given to a person for a charitable purpose were used by the donee to pay for services rendered or materials purchased in connection with the conduct of bingo by the donor organization.
24	The net proceeds of any game of bingo and of any rental of premises for bingo were not used exclusively for charitable purpose or were used by the donee for an activity that would not constitute a charitable purpose, if the activity were conducted by the donor organization.
25	A person failed to maintain records that fully and truly record all transactions connected with the conduct of Bingo, the leasing of premises to be used for the conduct of bingo, or the manufacture, sale, or distribution of bingo supplies or equipment.
26	A commercial lessor licensed to conduct bingo, did not properly deposit in its bingo checking account all rental payments from authorized organizations conducting bingo at the location of the lessor.

27	Rent for premises used for the conduct of bingo that was paid to the lessor was not paid in a lump sum that included all expenses authorized by the Bingo Enabling Act, Section 2001.458.
28	For organizations or units, deposits were made later than the end of the third business day following the day of the bingo occasion on which the receipts were obtained. [~~obtained.~~]

Category 4

$0 (Warning) to $300 for the 1st offense

$100 [~~$0 (Warning)~~] to $450 for the 2nd offense

$100 [~~$0 (Warning)~~] to $600 for the 3rd offense

No.	**Violation**
29	The organization or unit deposited funds, other than from the conduct of bingo, in the bingo account.
30	The organization failed to clearly identify the conductor, by name exactly as it is shown on the license, on an advertisement or promotion of a bingo occasion.
31	Check(s) or slip(s) were made payable to 'cash', 'bearer', or to a fictitious payee.
32	Checks did not contain the required information.

Category 5

$0 (Warning) to $200 for the 1st offense

$100 [~~$0 (Warning)~~] to $300 for the 2nd offense

$100 [~~$0 (Warning)~~] to $400 for the 3rd offense

No.	**Violation**

33	Funds from the sale of a bingo gift certificate were not maintained separately from bingo funds until the certificate was redeemed for a bingo card, pull-tab bingo or a card-minding device.
34	The organization failed to have required information imprinted on each bingo gift certificate.

Category 6

$0 (Warning) to $100 for the 1st offense

$50 [~~$0 (Warning)~~] to $150 for the 2nd offense

$50 [~~$0 (Warning)~~] to $200 for the 3rd offense

No.	Violation
35	The organization failed to withdraw funds from the bingo account by preprinted, consecutively numbered checks or withdrawal slips.
36	The organization failed to keep and account for all checks, including voided checks and slips.

Category 7

$0 (Warning) for the 1st offense

$50 [~~$0 (Warning)~~] for the 2nd offense

$50 [~~$0 (Warning)~~] to $1,000 for the 3rd offense

No.	Violation
37	The organization failed to obtain, maintain, keep current and make available for review to any person upon request a copy of the Bingo Enabling Act and the Rules of the Commission.

Figure: 16 TAC §402.707(g)

Expedited Administrative Penalty Chart

Violation	Penalty
The organization conducted bingo outside of the licensed time.	1st Offense - $200 2nd Offense - $300 3rd Offense - $500
The organization sold pull-tab bingo tickets at an unauthorized time.	1st Offense - $200 2nd Offense - $300 3rd Offense - $500
The organization that is a member of a unit did not conduct its bingo games separately from the bingo games of the other members of the unit.	1st Offense - Warn 2nd Offense - $300 3rd Offense - $500
The organization failed to have an authorized operator present at the bingo occasion.	1st Offense - $200 2nd Offense - $300 3rd Offense - $500
Prizes with an aggregate value of more than $5,000.00 for bingo games other than pull-tab bingo and prizes of $50 or less, as described in §2001.420(b)(2) of the Occupations Code, were offered or awarded for a single bingo occasion.	1st Offense - $200 2nd Offense - $300 3rd Offense - $500
The organization failed to prevent bingo workers from playing bingo.	1st Offense - $150 2nd Offense - $225 3rd Offense - $375
The organization offered or provided to a person the opportunity to play bingo without charge.	1st Offense - $150 2nd Offense - $225 3rd Offense - $375
The organization or lessor failed to conspicuously display the license issued at the place where the game was conducted at all times during the conduct of the game.	1st Offense - $100 2nd Offense - $150 3rd Offense - $250
The organization failed to have required information imprinted on each bingo gift certificate, specifically: the name and address of the licensed location(s) where the certificate may be redeemed for bingo paper, pull-tab bingo or card-minding devices; the monetary value of the certificate; the name of the licensed organization(s) authorized to accept the certificate; or the expiration date or blank space for the organization or unit to fill in an expiration date.	1st Offense - $50 2nd Offense - $75 3rd Offense - $125
A door prize with a value of more than $250.00 was offered or awarded.	1st Offense - $50 2nd Offense - $75

	3rd Offense - $125
The organization failed to conspicuously display during a bingo occasion a sign indicating the operator in charge, the sign contained letters less than one (1) inch in height, the sign failed to inform the players that they should direct any questions or complaints regarding the conduct of the bingo occasion to the operator listed on the sign, or the sign failed to state that if the player is not satisfied with the operators response that the player has the right to file a written formal complaint with the Commission.	1st Offense - $30 2nd Offense - $45 3rd Offense - $75
The organization failed to verify winning bingo cards by someone at another table or location other than the winners, or by an electronic verifier system, winning cards were not shown on a monitor visible to all players, or the disposable card(s) or electronic representation of the card, was not posted for inspection for at least 30 minutes after the completion of the last game of that organization's occasion.	1st Offense - $30 2nd Offense - $45 3rd Offense - $75
The organization failed to obtain, maintain, keep current and make available for review to any person upon request a copy of the Bingo Enabling Act and the Rules of the Commission.	1st Offense - Warn 2nd Offense - $50 [~~Warn~~] 3rd Offense - $75
Violations by a Worker	
A person not listed on the registry of approved bingo workers acted as an operator, manager, cashier, usher, caller, or salesperson for an organization.	1st Offense - Warn 2nd Offense - $45 3rd Offense - $75
A registered worker or operator for an organization did not wear, present, visibly display, or list the individuals name and unique registration number in a legible manner on his/her prescribed identification card, while on duty.	1st Offense - Warn 2nd Offense - $20 3rd Offense - $35

Figure: 43 TAC §11.59(d)(2)

Unadjusted Market Value	Fee
$0 - $499,999	$2,500
$500,000 - $1,999,999	$10,000
$2,000,000 or more	$25,000

In Addition

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of the Attorney General

Texas Water Code and Texas Health and Safety Code Settlement Notice

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement action under the Texas Water Code and the Texas Health and Safety Code. Before the State may enter into a voluntary settlement agreement, pursuant to section 7.110 of the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the law.

Case Title and Court: *Harris County, Texas, and the State of Texas, acting on behalf of the Texas Commission on Environmental Quality, a Necessary and Indispensable Party v. Samuel Waimun Shum, individually and d/b/a Samada, LLC, Ada Wing Leung, individually and d/b/a Samada, LLC, Samda, Inc., and Shum Garden*; Cause No. 2023-57660, in the 295th Judicial District, Harris County, Texas.

Nature of the Suit: This is an environmental enforcement action brought by Harris County against Samuel Waimun Shum, individually and d/b/a Samada, LLC, Ada Wing Leung, individually and d/b/a Samada, LLC, Samada, Inc., and Shum Garden for unpermitted development and unauthorized on-site sewage disposal systems. The State of Texas, on behalf of the Texas Commission on Environmental Quality, joined the suit as a necessary and indispensable party.

Proposed Settlement: The proposed Agreed Final Judgment and Permanent Injunction orders Defendants to comply with Harris County Floodplain Regulations. The proposed settlement also awards civil penalties in the amount of $6,102.00, to be equally divided between Harris County and the State; court costs in the amount of $898.00; and attorney's fees in the amount of $1,500.00 each to Harris County and the State.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment, and written comments on the proposed settlement, should be directed to Jaxon Welchman, Assistant Attorney General, Office of the Attorney General, P.O. Box 12548, MC 066, Austin, Texas 78711-2548, phone (512) 475-3205, facsimile (512) 320-0911, or email: Jaxon.Welchman@oag.texas.gov. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-202405177
Justin Gordon
General Counsel
Office of the Attorney General
Filed: October 30, 2024

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §303.003, §303.005, and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/11/24-11/17/24 is 18.00% for consumer[1] credit.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/11/24-11/17/24 is 18.00% for commercial[2] credit.

The monthly ceiling as prescribed by §303.005[3] and §303.009 for the period of 11/01/24-11/30/24 is 18.00%.

[1] Credit for personal, family, or household use.

[2] Credit for business, commercial, investment, or other similar purpose.

[3] Only for variable rate commercial transactions, as provided by §303.004(a).

TRD-202405334
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: November 6, 2024

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075, requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075, requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **December 13, 2024**. TWC, §7.075, also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be received by 5:00 p.m. on **December 13, 2024**. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission's enforce-

ment coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075, provides that comments on the AOs shall be submitted to the commission in writing.

(1) COMPANY: 32SII, LLC dba Chipper Point Apartments; DOCKET NUMBER: 2023-0783-PWS-E; IDENTIFIER: RN105068431; LOCATION: Lubbock, Lubbock County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.42(b)(1) and (e)(3), by failing to provide disinfection facilities for the groundwater supply for the purpose of microbiological control and distribution protection; PENALTY: $608; ENFORCEMENT COORDINATOR: Savannah Jackson, (512) 239-4306; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(2) COMPANY: American Ckritical Energy Systems, Incorporated; DOCKET NUMBER: 2024-0520-MLM-E; IDENTIFIER: RN101214930; LOCATION: Spring Branch, Comal County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §288.20(a) and §288.30(5)(B) and TWC, §11.1272(c), by failing to adopt a drought contingency plan which includes all elements for municipal use by a retail public water supplier; 30 TAC §290.42(l), by failing to compile and maintain a thorough and up-to-date plant operations manual for operator review and reference; 30 TAC §290.46(d)(2)(A) and §290.110(b)(4) and Texas Health and Safety Code, §341.0315(c), by failing to maintain a disinfectant residual of at least 0.2 milligrams per liter of free chlorine throughout the distribution system at all times; 30 TAC §290.46(f)(2) and (3)(A)(iii) and (B)(ii), by failing to maintain water works operation and maintenance records and make them readily available for review by the Executive Director upon request; 30 TAC §290.46(i), by failing to adopt an adequate plumbing ordinance, regulations, or service agreement with provisions for proper enforcement to ensure that neither cross-connections nor other unacceptable plumbing practices are permitted; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the system's facilities and equipment; 30 TAC §290.46(n)(1), by failing to maintain at the public water system accurate and up-to-date detailed as-built plans or record drawings and specifications for each treatment plant, pump station, and storage tank until the facility is decommissioned; 30 TAC §290.46(n)(3), by failing to keep on file copies of well completion data as defined in 30 TAC §290.41(c)(3)(A) for as long as the well remains in service; and 30 TAC §290.46(s)(1), by failing to calibrate the facility's four well meters at least once every three years; PENALTY: $3,714; ENFORCEMENT COORDINATOR: Ilia Perez-Ramirez, (713) 767-3743; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(3) COMPANY: Bell County Water Control and Improvement District 2; DOCKET NUMBER: 2023-1389-MWD-E; IDENTIFIER: RN101610418; LOCATION: Little River Academy, Bell County; TYPE OF FACILITY: wastewater treatment plant; RULES VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a)(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0011091001, Effluent Limitations and Monitoring Requirements Numbers 1, 2, and 6, by failing to comply with permitted effluent limitations; PENALTY: $109,200; ENFORCEMENT COORDINATOR: Kolby Farren, (512) 239-2098; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(4) COMPANY: Blue Cube Operations LLC; DOCKET NUMBER: 2024-0306-AIR-E; IDENTIFIER: RN108772245; LOCATION: Freeport, Brazoria County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §101.10(b)(2) and §122.143(4), Federal Operating Permit (FOP) Number O2207, General Terms and Conditions (GTC) and Special Terms and Conditions (STC) Number 2.E., and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit an annual emissions inventory update that consists of actual emissions; and 30 TAC §116.115(c) and §122.143(4), New Source Review Permit Number 5340, Special Conditions Number 9, FOP Number O1388, GTC and STC Number 20, and THSC, §382.085(b), by failing to maintain the thermal oxidizer firebox exit temperature equal to or greater than the respective hourly average temperature established during the most recent satisfactory stack testing; PENALTY: $45,938; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $18,375; ENFORCEMENT COORDINATOR: Caleb Martin, (512) 239-2091; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(5) COMPANY: City of Poth; DOCKET NUMBER: 2024-0099-PWS-E; IDENTIFIER: RN101390367; LOCATION: Poth, Wilson County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.39(j)(1)(A) and Texas Health and Safety Code, §341.0351, by failing to notify the Executive Director and receive approval prior to making any significant change or addition where the change in the existing distribution system results in an increase or decrease in production, treatment, storage, or pressure maintenance; 30 TAC §290.41(c)(3)(A), by failing to submit well completion data for review and approval prior to placing the facility's public drinking water Well Number 5 into service; and 30 TAC §290.45(b)(1)(D)(iii) and THSC, §341.0315(c), by failing to provide two or more pumps that have a total capacity of 2.0 gallons per minute (gpm) per connection or that have a total capacity of at least 1,000 gpm and the ability to meet peak hourly demands with the largest pump out of service, whichever is less; PENALTY: $1,250; ENFORCEMENT COORDINATOR: Hilda Iyasele, (512) 239-5280; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(6) COMPANY: City of Rotan; DOCKET NUMBER: 2024-0575-PWS-E; IDENTIFIER: RN101440659; LOCATION: Rotan, Fisher County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.115(f)(1) and Texas Health and Safety Code, §341.0315(c), by failing to comply with the maximum contaminant level of 0.080 milligrams per liter for total trihalomethanes, based on the locational running annual average; 30 TAC §290.117(c)(2)(A), (h) and (i)(1), by failing to collect lead and copper tap samples at the required 20 sample sites, have the samples analyzed, and report the results to the executive director (ED) for the January 1, 2023 - June 30, 2023, and July 1, 2023 - December 31, 2023, monitoring periods; 30 TAC §290.117(c)(2)(B), (h) and (i)(1), by failing to collect lead and copper tap samples at the required ten sample sites, have the samples analyzed, and report the results to the ED for the January 1, 2022 - December 31, 2022, monitoring period; and 30 TAC §290.117(c)(2)(C), (h) and (i)(1), by failing to collect lead and copper tap samples at the required ten sample sites, have the samples analyzed, and report the results to the ED for the January 1, 2019 - December 31, 2021, monitoring period; PENALTY: $5,910; ENFORCEMENT COORDINATOR: Emerson Rinewalt, (512) 239-1131; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(7) COMPANY: CYPRESS CREEK Water Supply Corporation; DOCKET NUMBER: 2024-0419-PWS-E; IDENTIFIER: RN101235760; LOCATION: Woodville, Tyler County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.117(d)(2)(A), (h) and (i)(2), by failing to collect one lead and copper sample from the facility's one entry point no later than 180 days after the end of the January 1, 2023 - June 30, 2023, monitoring period during which the copper action level was exceeded, have the samples analyzed, and report the results to the executive director (ED); 30 TAC §290.117(f)(3)(A), by failing to submit a recommendation to the ED for optimal corrosion control treatment within six months

after the end of the January 1, 2023 - June 30, 2023, monitoring period during which the copper action level was exceeded; 30 TAC §290.117(g)(2)(A), by failing to submit a recommendation to the ED for source water treatment within 180 days after the January 1, 2023 - June 30, 2023, monitoring period during which the copper action level was exceeded; 30 TAC §290.117(i)(6) and (j), by failing to provide a consumer notification of lead tap water monitoring results to persons served at the sites that were tested, and failing to mail a copy of the consumer notification of tap results to the ED along with a certification that the consumer notification had been distributed in a manner consistent with TCEQ requirements for the January 1, 2023 - June 30, 2023, monitoring period; and 30 TAC §290.122(c)(2)(A) and (f), by failing to provide a public notification, accompanied with a signed Certificate of Delivery, to the ED regarding the failure to collect lead and copper tap samples at the required twenty sample sites, have the samples analyzed, and report the results to the ED for the January 1, 2020 - December 31, 2020, January 1, 2021 - December 31, 2021, and January 1, 2022 - June 30, 2022, monitoring periods and regarding the failure to submit a Disinfection Level Quarterly Operating Report to the ED by the tenth day of the month following the end of each quarter for the third quarter of 2022; PENALTY: $5,312; ENFORCEMENT COORDINATOR: Ilia Perez-Ramirez, (713) 767-3743; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(8) COMPANY: FRIBERG-COOPER WATER SUPPLY CORPORATION; DOCKET NUMBER: 2024-0620-PWS-E; IDENTIFIER: RN101439487; LOCATION: Wichita Falls, Wichita County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.46(q)(1)(A)(i), by failing to institute special precautions as described in the flowchart found in 30 TAC §290.47(e) in the event of low distribution pressure and water outages; PENALTY: $780; ENFORCEMENT COORDINATOR: Daphne Greene, (903) 535-5157; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(9) COMPANY: JF Excavation and Materials, LLC; DOCKET NUMBER: 2023-0043-WQ-E; IDENTIFIER: RN111611430; LOCATION: Willis, Montgomery County; TYPE OF FACILITY: aggregate production operation (APO); RULES VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations §122.26(c), by failing to maintain authorization to discharge stormwater associated with industrial activities; and 30 TAC §342.25(b), by failing to register the site as an APO no later than the tenth business day before the beginning date of regulated activities; PENALTY: $11,750; ENFORCEMENT COORDINATOR: Monica Larina, (361) 881-6965; REGIONAL OFFICE: 500 North Shoreline Boulevard, Suite 500, Corpus Christi, Texas 78401, (361) 881-6900.

(10) COMPANY: McRae Partners I, Ltd.; DOCKET NUMBER: 2024-0542-PWS-E; IDENTIFIER: RN105196158; LOCATION: Kerrville, Kerr County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.39(h)(3) and (j)(1)(A) and Texas Health and Safety Code, §341.0351, by failing to notify the Executive Director in writing as to the completion of a water works project and attest to the fact that the completed work is substantially in accordance with the plans and specifications on file with the commission; and 30 TAC §290.41(c)(3)(A), by failing to submit well completion data for review and approval prior to placing the facility's public drinking water well into service; PENALTY: $1,000; ENFORCEMENT COORDINATOR: Mason DeMasi, (210) 657-8425; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 492-3096.

(11) COMPANY: North Collin Special Utility District; DOCKET NUMBER: 2024-0637-PWS-E; IDENTIFIER: RN101458552; LOCATION: Princeton, Collin County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.45(b)(1)(D)(i) and Texas Health and Safety Code, §341.0315(c), by failing to provide two or more wells having a total capacity of 0.6 gallons per minute per connection; PENALTY: $750; ENFORCEMENT COORDINATOR: Emerson Rinewalt, (512) 239-1131; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(12) COMPANY: RACETRAC INCORPORATED; DOCKET NUMBER: 2024-1422-PST-E; IDENTIFIER: RN102269487; LOCATION: Dallas, Dallas County; TYPE OF FACILITY: operator; RULE VIOLATED: 30 TAC §334.50(b)(1)(A), by failing to monitor underground storage tanks for releases at least once every 30 days; PENALTY: $5,250; ENFORCEMENT COORDINATOR: Adriana Fuentes, (956) 430-6057; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(13) COMPANY: Riverbend Water Resources District; DOCKET NUMBER: 2024-0120-IWD-E; IDENTIFIER: RN101274231; LOCATION: New Boston, Bowie County; TYPE OF FACILITY: municipal wastewater treatment plant; RULES VIOLATED: 30 TAC §305.121(1), TWC, §26.121(a)(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0004664000, Phase I Effluent Limitations and Monitoring Requirements Number 1 for Outfall Number 101 and Phase I Effluent Limitations and Monitoring Requirements Numbers 1 and 2 for Outfall Number 001, by failing to comply with permitted effluent limitations; PENALTY: $25,463; ENFORCEMENT COORDINATOR: Taylor Williamson, (512) 239-2097; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(14) COMPANY: RLB CONTRACTING, INCORPORATED; DOCKET NUMBER: 2023-0647-WQ-E; IDENTIFIER: RN111720637; LOCATION: Point Comfort, Calhoun County; TYPE OF FACILITY: home building site; RULES VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations §122.26(c), by failing to obtain authorization to discharge stormwater associated with construction activities; PENALTY: $7,500; ENFORCEMENT COORDINATOR: Wyatt Throm, (512) 239-1120; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(15) COMPANY: SJRR Power, LLC; DOCKET NUMBER: 2022-0902-AIR-E; IDENTIFIER: RN110723897; LOCATION: Channelview, Harris County; TYPE OF FACILITY: natural gas power station; RULES VIOLATED: 30 TAC §122.143(4) and §122.146(1) and (2), Federal Operating Permit Number O4153, General Terms and Conditions and Special Terms and Conditions Number 9, and Texas Health and Safety Code, §382.085(b), by failing to certify compliance with the terms and conditions of the permit for at least each 12-month period following initial permit issuance, and failing to submit a permit compliance certification within 30 days of any certification period; PENALTY: $7,700; ENFORCEMENT COORDINATOR: Johnnie Wu, (512) 239-2524; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(16) COMPANY: SUPER DIAMOND EAGLE INCORPORATED dba Eagle C-Store Hwy 69; DOCKET NUMBER: 2024-0686-PST-E; IDENTIFIER: RN102273315; LOCATION: Tyler, Smith County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tanks (USTs) in a manner which will detect a release at a frequency of at least once every 30 days, and failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $5,180; ENFORCEMENT COORDINATOR: Ramyia Wendt, (512) 239-2513; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(17) COMPANY: VAM USA, LLC; DOCKET NUMBER: 2023-1409-MWD-E; IDENTIFIER: RN102186194; LOCATION: Houston, Harris County; TYPE OF FACILITY: wastewater treatment facility; RULES VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a)(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0015026001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; PENALTY: $7,125; ENFORCEMENT COORDINATOR: Samantha Smith, (512) 239-2099; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(18) COMPANY: Wild Boar Ranch, LP; DOCKET NUMBER: 2024-0612-PWS-E; IDENTIFIER: RN108433103; LOCATION: Fredericksburg, Gillespie County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.39(h)(3) and (j)(1)(A) and Texas Health and Safety Code, §341.0351, by failing to notify the Executive Director in writing as to the completion of a water works project and attest to the fact that the completed work is substantially in accordance with the plans and specifications on file with the commission; PENALTY: $1,050; ENFORCEMENT COORDINATOR: Ilia Perez-Ramirez, (512) 239-2556; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(19) COMPANY: WORTHAM OAKS HOMEOWNERS ASSOCIATION, INCORPORATED; DOCKET NUMBER: 2024-0314-EAQ-E; IDENTIFIER: RN106359268; LOCATION: San Antonio, Bexar County; TYPE OF FACILITY: residential community; RULE VIOLATED: 30 TAC §213.4(k) and Edwards Aquifer Protection Plan ID Number 13-14082101, Standard Conditions Number 19, by failing to maintain the permanent best management practices after construction until such time as the maintenance obligation is either assumed in writing by another entity having ownership or control of the property; PENALTY: $3,375; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $1,350; ENFORCEMENT COORDINATOR: Megan Crinklaw, (512) 239-1129; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-2545.

(20) COMPANY: Wyman-Gordon Forgings, Incorporated; DOCKET NUMBER: 2024-1576-AIR-E; IDENTIFIER: RN100217413; LOCATION: Houston, Harris County; TYPE OF FACILITY: steel forging plant; RULES VIOLATED: 30 TAC §§122.121, 122.133(2), and 122.241(b), and Texas Health and Safety Code, §382.054 and §382.085(b), by failing to submit a permit renewal application at least six months prior to the expiration of a federal operating permit; PENALTY: $7,650; ENFORCEMENT COORDINATOR: Trenton White, (903) 535-5155; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

TRD-202405318
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: November 5, 2024

Enforcement Orders

A default order was adopted regarding Daryll Hawes aka Darryl Hawes, Docket No. 2021-0023-MLM-E on November 6, 2024 assessing $13,281 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Barrett Hollingsworth, Staff Attorney at (512) 239 3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711 3087.

An agreed order was adopted regarding City of Humble, Docket No. 2022-0130-MLM-E on November 6, 2024 assessing $15,750 in administrative penalties with $3,150 deferred. Information concerning any aspect of this order may be obtained by contacting Monica Larina, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An default order was adopted regarding John Phillip Reeves, Docket No. 2022-0196-AIR-E on November 6, 2024 assessing $6,250 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Cynthia Sirois, Staff Attorney at (512) 239 3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711 3087.

An agreed order was adopted regarding NEDERLAND TANK WASH, INC., Docket No. 2022-0495-AIR-E on November 6, 2024 assessing $59,004 in administrative penalties with $11,800 deferred. Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Intercontinental Terminals Company LLC, Docket No. 2022-0827-IWD-E on November 6, 2024 assessing $26,775 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Cynthia Sirois, Staff Attorney at (512) 239 3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711 3087.

An agreed order was adopted regarding INEOS Styrolution America LLC, Docket No. 2022-1110-AIR-E on November 6, 2024 assessing $32,625 in administrative penalties with $6,525 deferred. Information concerning any aspect of this order may be obtained by contacting Desmond Martin, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding WOODLAND OAKS UTILITY, LP, Docket No. 2022-1373-MWD-E on November 6, 2024 assessing $15,152 in administrative penalties with $3,030 deferred. Information concerning any aspect of this order may be obtained by contacting Taylor Williamson, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was adopted regarding Randy Howell, Docket No. 2022-1435-MSW-E on November 6, 2024 assessing $5,000 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Alexander Kepczyk, Staff Attorney at (512) 239 3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711 3087.

An agreed order was adopted regarding ATKINSON CANDY COMPANY, Docket No. 2023-0030-WQ-E on November 6, 2024 assessing $60,000 in administrative penalties with $12,000 deferred. Information concerning any aspect of this order may be obtained by contacting Arti Patel, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Patrick Griffin, Docket No. 2023-0078-MLM-E on November 6, 2024 assessing $29,250 in administrative penalties with $5,850 deferred. Information concerning any aspect of this order may be obtained by contacting Nancy Sims, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Webb County, Docket No. 2023-0493-PWS-E on November 6, 2024 assessing $4,500 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Taner Hengst, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Texas Department of Transportation, Docket No. 2023-0751-MWD-E on November 6, 2024 assessing $14,250 in administrative penalties with $2,850 deferred. Information concerning any aspect of this order may be obtained by contacting Samantha Smith, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding MDB Enterprises, Inc., Docket No. 2023-0946-WQ-E on November 6, 2024 assessing $17,500 in administrative penalties with 3,500 deferred. Information concerning any aspect of this order may be obtained by contacting Mark Gamble, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Borden County, Docket No. 2024-0163-PWS-E on November 6, 2024 assessing $1,787 in administrative penalties with $1,312 deferred. Information concerning any aspect of this order may be obtained by contacting Kaisie Hubschmitt, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Space Exploration Technologies Corp., Docket No. 2024-1282-IWD-E on November 6, 2024 assessing $3,750 in administrative penalties with $750 deferred. Information concerning any aspect of this order may be obtained by contacting Mistie Gonzales, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-202405355
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of an Amendment to a Certificate of Adjudication Application No. 10-3980B

Notice Issued October 24, 2024

Riceland Landvest, LLC, LP (Owner/Applicant), 15915 Katy Freeway, Suite 405, Houston, Texas 77094-1710, seeks to amend its portion of Certificate of Adjudication No. 10-3980 to sever the irrigation rights from the appurtenant land, add municipal use, and change the place of use for agriculture and municipal purposes to Harris County. Applicant also seeks to add an exempt interbasin transfer to those portions of Harris County within the Trinity-San Jacinto and San Jacinto-Brazos Coastal Basins.

More information on the application and how to participate in the permitting process is given below.

The Executive Director has completed the technical review of the application and prepared a draft permit. The application and fees were received on June 12, 2023. The application was declared administratively complete and accepted for filing with the Office of the Chief Clerk on July 18, 2023.

The Executive Director has completed the technical review of the application and prepared a draft amendment. The draft amendment, if granted, would contain special conditions related to water conservation and drought contingency plans. The application, technical memoranda, and Executive Director's draft amendment are available for viewing on the TCEQ webpage at: https://www.tceq.texas.gov/permitting/water_rights/wr-permitting/view-wr-pend-apps. Alternatively, you may request a copy of the documents by contacting the TCEQ Office of the Chief Clerk by phone at (512) 239-3300 or by mail at TCEQ OCC, Notice Team (MC-105), P.O. Box 13087, Austin, Texas 78711.

Written public comments and requests for a public meeting should be submitted to the Office of the Chief Clerk, at the address provided in the information section below by November 12, 2024. A public meeting is intended for the taking of public comment and is not a contested case hearing. A public meeting will be held if the Executive Director determines that there is a significant degree of public interest in the application.

The TCEQ may grant a contested case hearing on this application if a written hearing request is filed by November 12, 2024. The Executive Director may approve the application unless a written request for a contested case hearing is filed by November 12, 2024.

To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) applicant's name and permit number; (3) the statement "[*I/we*] request a contested case hearing;" (4) a brief and specific description of how you would be affected by the application in a way not common to the general public; and (5) the location and distance of your property relative to the proposed activity. You may also submit proposed conditions for the requested permit which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below.

If a hearing request is filed, the Executive Director will not issue the permit and will forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments, or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087 or electronically at https://www14.tceq.texas.gov/epic/eComment/ by entering ADJ 5311 in the search field. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address.

For additional information, individual members of the general public may contact the Public Education Program at (800) 687-4040. General information regarding the TCEQ can be found at our website at www.tceq.texas.gov. Si desea información en español, puede llamar al (800) 687-4040 o por el internet al www.tceq.texas.gov.

TRD-202405344
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of District Petition TCEQ Internal Control No. D-06272024-061

Notice issued October 30, 2024

TCEQ Internal Control No. D-06272024-061; Kendall County Water Control and Improvement District No. 4 (the "District") filed an application with the Texas Commission on Environmental Quality (TCEQ) for authority to levy an impact fee of $9,241 per connection within the District's service area. The District files this application under the authority of Chapter 395 of the Local Government Code, 30 Texas Administrative Code Chapter 293, and the procedural rules of the TCEQ. The purpose of impact fees is to generate revenue to recover the costs of

capital improvements or facility expansions made necessary by and attributable to serving new development in the District's regional service area. At the direction of the District, a registered engineer has prepared a capital improvements plan for the system that identifies the capital improvements or facility expansions and their costs for which the impact fees will be assessed. The impact fee application and supporting information are available for inspection and copying during regular business hours in the Districts Section of the Water Supply Division, Third Floor of Building F (in the TCEQ Park 35 Office Complex located between Yager and Braker lanes on North IH-35), 12100 Park 35 Circle, Austin, Texas 78753. A copy of the impact fee application and supporting information, as well as the capital improvements plan, is available for inspection and copying at the District's office during regular business hours.

INFORMATION SECTION

To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405347
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of District Petition TCEQ Internal Control No. D-09252024-046

Notice issued October 31, 2024

TCEQ Internal Control No. D-09252024-046: 4 Corners Builders & Developers, LLC and Sylvia A. Poessel Testamentary Trust, (Petitioners) filed a petition for creation of Fort Bend County Municipal Utility District No. 273 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, §59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioners hold title to a majority in value of the land to be included in the proposed District; (2) there is one lienholder, The First State Bank, Louise, a state chartered bank, on the property to be included in the proposed District and information provided indicates that the lienholder consents to the creation of the proposed District; (3) the proposed District will contain approximately 324.20 acres located within Fort Bend County, Texas; and (4) none of the land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any city. The petition further states that the proposed District will: (1) purchase, design, construct, acquire, maintain, own, operate, repair, improve, and extend a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, improve, extend, maintain, and operate works, improvements, facilities, plants, equipment, and appliances helpful or necessary to provide more adequate drainage for the proposed District; (3) control, abate, and amend local storm waters or other harmful excesses of water; and (4) purchase, construct, acquire, maintain, own, operate, repair, improve, and extend such additional facilities, including roads, parks and recreation facilities, systems, plants, and enterprises as shall be consonant with all of the purposes for which the proposed District is created. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioners that the cost of said project will be approximately $92,600,000 ($61,800,000 for water, wastewater, and drainage, $21,100,000 for roads, and $9,700,000 for recreational).

INFORMATION SECTION

To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405348
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

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Notice of District Petition TCEQ Internal Control No. D-09302024-052

Notice issued October 31, 2024

TCEQ Internal Control No. D-09302024-052: Chesmar Homes, LLC and Brandt Ranch, LLC, (Petitioners) filed a petition for creation of Purlsong Municipal Management District of Comal County (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapter 375, Texas Local Government Code; Chapter 49 of the Texas Water Code; Title 30, Chapter 293 of the Texas Administrative Code; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioners hold title to a majority in value of the land to be included in the proposed District; (2): there is one lienholder, Pinnacle Bank, on the property to be included in the proposed District and information provided indicates that the lienholder consents to the creation of the proposed District; (3) the proposed District will contain approximately 835.159 acres located within Comal County, Texas; and (4) none of the land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any city. The petition further states that the proposed District will: (1) purchase, construct, acquire, maintain, own, operate, repair, improve, and extend a waterworks and sanitary sewer system for residential and commercial purposes; (2) construct, acquire, improve, extend, maintain and operate works, improvements, facilities, plants, equipment, and appliances helpful or necessary to provide more adequate drainage for the proposed District; (3) control, abate, and amend local stormwaters or other harmful excesses of waters; and (4) purchase, construct, acquire, improve, maintain, and operate, repair, improve, and extend such additional facilities, including roads, systems, plants and enterprises as shall be consonant with the purposes for which the proposed District is created. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioners that the cost of said project will be approximately $234,757,032 ($166,557,662 for water, wastewater, and drainage and $68,199,370 for roads).

INFORMATION SECTION

To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405349
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

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Notice of District Petition TCEQ Internal Control No. D-09302024-058

Notice issued October 30, 2024 TCEQ Internal Control No. D-09302024-058: Utilities, Inc. of Texas, a Delaware corporation, and Turner Land & Hay, LLC, a Texas limited liability company (Petitioners) filed a petition for creation of Bastrop County Municipal Utility District No. 7 (District) of Bastrop County with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, §59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioners hold title to a majority in value of the land to be included in the proposed District; (2) there are no lienholders on the property to be included in the proposed District; and (3) none of the land is located within the corporate limits or extraterritorial jurisdiction of any city in Texas. The petition further states that the proposed District will design, construct, acquire, improve, extend, finance, and issue bonds for: (1) maintenance, operation, and conveyance of an adequate and efficient water works and sanitary sewer system for domestic purposes; (2) maintenance, operation, and conveyance of works, improvements, facilities, plants, equipment, and appliances helpful or necessary to provide more adequate drainage for the District, and to control, abate, and amend local storm waters or other harmful excesses of waters; (3) maintenance, operation, and conveyance of park and recreational facilities; (4) conveyance of roads and improvements in aid of roads; and (5) maintenance, operation, and conveyance of such other additional facilities, systems, plants, and enterprises as may be consistent with any or all of the purposes for which the District is created

According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioners that the cost of said project will be approximately $84,850,000 ($45,300,000 for water, wastewater, and drainage plus $14,900,000 for recreation plus $25,100,000 for roads). INFORMATION SECTION To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing re-

quest is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding like a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405345
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of District Petition TCEQ Internal Control No. D-10072024-011

Notice issued October 31, 2024 TCEQ Internal Control No. D-10072024-011: Chesmar Homes, LLC, a Texas limited liability company, (Petitioner) filed a petition for creation of Regency Ranch Improvement District of Guadalupe County (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Texas Constitution, Chapter 375, Texas Local Government Code and Chapter 49, Texas Water Code, and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner holds title to a majority in value of the land to be included in the proposed District; (2) there are no lienholders on the property to be included in the proposed District; (3) the proposed District will contain approximately 33.132 acres located within Guadalupe County, Texas; and (4) none of the land within the proposed District is wholly within the corporate limits or extraterritorial jurisdiction of any city. The petition further states that the proposed District will: (1) purchase, design, construct, acquire, maintain, own, operate, repair, improve and extend a waterworks and sanitary wastewater system for residential and commercial purposes; (2) construct, acquire, improve, extend maintain and operate of works, improvements, facilities, plants, equipment and appliances helpful or necessary to provide more adequate drainage for the proposed District; (3) control, abate and amend local storm waters or other harmful excesses of waters; and, (4) such other purchase, construction, acquisition, maintenance, ownership, operation, repair, improvement and extension of such additional facilities, including roads, systems, plants and enterprises as shall be consistent with all of the purposes for which the proposed District is created. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioners that the cost of said project will be approximately $3,495,000 ($2,210,000 for water, wastewater, and drainage plus $1,285,000 for roads).

INFORMATION SECTION

To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405350
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of District Petition TCEQ Internal Control No. D-10092024-015

Notice issued October 30, 2024

TCEQ Internal Control No. D-10092024-015: Martin Land Ventures, LTD., (Petitioner) filed a petition for creation of Montgomery County Municipal Utility District No. 251 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, §59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner holds title to a majority in value of the land to be included in the proposed District; (2) there is one lienholder, Capital Farm Credit, ACA, a federally chartered institution of the Farm Credit System and an instrumentality of the government of the United States of America, on the property to be included in the pro-

posed District and the lienholder consents to the creation of the proposed District; (3) the proposed District will contain approximately 338.559 acres located within Montgomery County, Texas; and (4) none of the land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any city. The petition further states that the proposed District will: (1) purchase, construct, acquire, improve, extend, maintain, and operate a waterworks and wastewater system for domestic and commercial purposes; (2) purchase, construct, acquire, improve, extend, maintain, and operate works, improvements, facilities, plants, equipment, and appliances helpful or necessary to provide more adequate drainage for the proposed District; and (3) control, abate, and amend local storm waters or other harmful excesses of water. The proposed District also intends to purchase interests in land and purchase, construct, acquire, improve, extend, maintain, and operate improvements, facilities, and equipment for the purpose of providing recreational facilities. Pursuant to Section 54.234, Texas Water Code, as amended, the proposed District may also exercise road powers and authority pursuant to applicable law, and pursuant to applicable law, the proposed District may also establish, finance, provide, operate, and maintain a fire department and/or fire-fighting services within the proposed District. This expression is not intended to limit the future powers and purposes of the proposed District, or the acquisition, financing, operation, maintenance by the proposed District of such additional facilities, systems, plants, and enterprises as shall be consonant with all of the purposes for which the proposed District is created. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioner that the cost of said project will be approximately $51,125,000 ($31,450,000 for water, wastewater, and drainage plus $12,875,000 for roads plus $6,800,000 for recreational facilities).

INFORMATION SECTION

To view the complete issued notice, view the notice on our website at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the website, type in the issued date range shown at the top of this document to obtain search results. The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our website at www.tceq.texas.gov.

TRD-202405346
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of Opportunity to Comment on an Agreed Order of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Order (AO) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075, requires that before the commission may approve the AO, the commission shall allow the public an opportunity to submit written comments on the proposed AO. TWC, §7.075, requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **December 13, 2024**. TWC, §7.075, also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of the proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on December 13, 2024**. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, TWC, §7.075, provides that comments on an AO shall be submitted to the commission in **writing**.

(1) COMPANY: Arnona Inc. dba Sunny Market & Deli; DOCKET NUMBER: 2022-0538-PST-E; TCEQ ID NUMBER: RN101447688; LOCATION: 6001 North Main Street, Fort Worth, Tarrant County; TYPE OF FACILITY: underground storage tank (UST) system; RULES VIOLATED: TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide corrosion protection for the UST system; PENALTY: $3,375; STAFF ATTORNEY: William Hogan, Litigation, MC 175, (512) 239-5918; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

TRD-202405333
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: November 6, 2024

Notice of Public Meeting Cancellation

The Texas Commission on Environmental Quality (TCEQ) submitted a Notice of Public Meeting for TPDES Permit for Municipal Wastewater New Permit Number WQ0016342001 for Space Exploration Technologies Corporation, for publication in the October 18, 2024, issue of the *Texas Register,* TexReg Docket Number 202404797. The public meeting scheduled for Thursday, November 14, 2024 is cancelled.

Members of the public with questions regarding this application or public meeting may seek further information by calling the TCEQ Public Education Program toll free at (800) 687-4040.

TRD-202405351
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 6, 2024

Texas Ethics Commission

List of Delinquent Filers

LIST OF LATE FILERS

Below is a list from the Texas Ethics Commission naming the filers who failed to pay the penalty fine for failure to file the report, or filing a late report, in reference to the specified filing deadline. If you have any questions, you may contact Dave Guilianelli at (512) 463-5800.

Deadline: Personal Financial Statement due July 22, 2024

#00083830 - Santos Vargas, 99 Sunriver, Boerne, Texas 78006

#00088852 - Andrew Spaniol, 1500 Marilla St., Ste. 7DN, Dallas, Texas 75201

Deadline: Personal Financial Statement due September 18, 2024

#00088880 - Jeffrey L. McGunegle, 6017 Jameson Road #8, Amarillo, Texas 79106

#00088915 - Nancy A. Nichols, 11650 County Road 4215, Tyler, Texas 75706

#00088951 - Seth NMN Steele, P.O. Box 1219, Rye, Texas 77364

TRD-202405315
J.R. Johnson
Executive Director
Texas Ethics Commission
Filed: November 4, 2024

Texas Health and Human Services Commission

Notice of Public Hearing on Proposed Updates to Medicaid Payment Rates for Medical Policy Reviews, Special Review and HCPCS Quarterly Updates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on December 4, 2024, at 9:00 a.m., to receive public comments on proposed updates to Medical Policy Reviews, HCPCS Quarterly Updates and a Special Review.

This hearing will be conducted as an online event only. To join the hearing from your computer, tablet, or smartphone, register for the hearing in advance using the following link:

Registration URL:

https://attendee.gotowebinar.com/register/7914903065335951960

After registering, you will receive a confirmation email containing information about joining the webinar. Instructions for dialing-in by phone will be provided after you register.

A recording of the hearing will be archived and accessible on demand at https://www.hhs.texas.gov/about/live-archived-meetings under the "Archived" tab. The hearing will be held in compliance with Texas Human Resources Code section 32.0282, which requires public notice of and hearings on proposed Medicaid reimbursements.

Any updates to the hearing details will be posted on the HHSC website at https://www.hhs.texas.gov/about/meetings-events.

Proposal. The effective date of the proposed payment rates for the topics presented during the rate hearing will be as follows:

Effective September 01, 2024

Medical Policy Review:

-Influenza Vaccine-90653

Effective October 01, 2024

Medical Policy Review:

-COVID-19 End-Dated Codes

Effective December 01, 2024

Special Review:

-ASC/HASC End-Dated codes

Effective March 22, 2024

HCPCS Quarterly Updates:

-Q2 HCPCS-Q0224

-Q2 HCPCS Non Drugs- M0224

Effective March 1, 2025

HCPCS Quarterly Updates:

-Q2 HCPCS Non Drugs- TOS F

-Q2 HCPCS Non Drugs- TOS 2

Methodology and Justification. The proposed payment rates were calculated in accordance with Title 1 of the Texas Administrative Code:

Section 355.8085, Reimbursement Methodology for Physicians and Other Practitioners;

Section 355.8121, Reimbursement to Ambulatory Surgical Centers;

Section 355.8441, Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (also known as Texas Health Steps);

Rate Hearing Packet. A briefing packet describing the proposed payment rates will be made available at https://pfd.hhs.texas.gov/rate-packets on or before November 24, 2024. Interested parties may obtain a copy of the briefing packet on or after that date by contacting Provider Finance by telephone at (512) 730-7401; by fax at (512) 730-7475; or by e-mail at PFDAcuteCare@hhs.texas.gov.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the Texas Health and Human Services Commission, Attention: Provider Finance, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030; by fax to Provider Finance at (512) 730-7475; or by e-mail to PFDAcuteCare@hhs.texas.gov. In addition, written comments may be sent by overnight mail to Texas Health and Human Ser-

vices Commission, Attention: Provider Finance, Mail Code H-400, North Austin Complex, 4601 Guadalupe St, Austin, Texas 78751.

Preferred Communication. For quickest response please use e-mail or phone if possible for communication with HHSC related to this rate hearing.

Persons with disabilities who wish to participate in the hearing and require auxiliary aids or services should contact Provider Finance at (512) 730-7401 at least 72 hours before the hearing so appropriate arrangements can be made.

TRD-202405332
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: November 6, 2024

Public Notice - Texas State Plan for Medical Assistance Amendment

The Texas Health and Human Services Commission (HHSC) announces its intent to submit amendments to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendments will be effective December 1, 2024.

The purpose of the amendments is to update the fee schedules in the current state plan by adjusting fees, rates, or charges for the following service:

Ambulatory Surgical Center (ASC).

The proposed amendment is estimated to result in an annual aggregate expenditure of $0 for federal fiscal year (FFY) 2025, consisting of $0 in federal funds and $0 in state general revenue. For FFY 2026, the estimated annual aggregate expenditure is $0 consisting of $0 in federal funds and $0 in state general revenue. For FFY 2027, the estimated annual aggregate expenditure is $0 consisting of $0 in federal funds and $0 in state general revenue.

Further detail on specific reimbursement rates and percentage changes will be made available on the HHSC Provider Finance website under the proposed effective date at: https://pfd.hhs.texas.gov/rate-packets.

Rate Hearings.

A rate hearing will be conducted online on December 4th, 2024. Information about the proposed rate changes and hearing will be published in the current issue of the *Texas Register*. Additional information and the notice of hearings can be found at https://www.sos.state.tx.us/texreg/index.shtml. Archived recordings of the hearings can be found at https://www.hhs.texas.gov/about/meetings-events.

Copy of Proposed Amendment.

Interested parties may obtain additional information and/or a free copy of the proposed amendment by contacting Nicole Hotchkiss, State Plan Policy Advisor, by mail at the Health and Human Services Commission, P.O. Box 13247, Mail Code H-600, Austin, Texas 78711; by telephone at (512) 487-3349; by facsimile at (512) 730-7472; or by e-mail at Medicaid_Chip_SPA_Inquiries@hhsc.state.tx.us. Once submitted to the Centers for Medicare and Medicaid Services for approval, copies of the proposed amendment will be available for review at the HHSC Access and Eligibility Services for local benefit offices.

Written Comments.

Written comments about the proposed amendment and/or requests to review comments may be sent by U.S. mail, overnight mail, special delivery mail, hand delivery, fax, or email:

U.S. Mail

Texas Health and Human Services Commission

Attention: Provider Finance Department

Mail Code H-400

P.O. Box 149030

Austin, Texas 78714-9030

Overnight mail, special delivery mail, or hand delivery

Texas Health and Human Services Commission

Attention: Provider Finance Department

North Austin Complex

Mail Code H-400

4601 W. Guadalupe St.

Austin, Texas 78751

Phone number for package delivery: (512) 730-7401

Fax

Attention: Provider Finance at (512) 730-7475

Email

PFDAcuteCare@hhs.texas.gov

Preferred Communication.

For quickest response, please use e-mail or phone, if possible, for communication with HHSC related to this state plan amendment.

TRD-202405331
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: November 6, 2024

Texas Department of Housing and Community Affairs

TDHCA Governing Board Approved Draft of 2025 Streamlined Annual Public Housing Authority Plan

A draft of the 2025 Streamlined Annual Public Housing Authority Plan (PHA Plan) that was approved by the TDHCA Governing Board on October 10, 2024.

Public Comment Period: Starts: 8:00 a.m. Central time on Monday, November 18, 2024

Ends: 5:00 p.m. Central time on Monday, December 16, 2024

Comments received after 5:00 p.m. Central time on Monday, December 16, 2024 will not be accepted.

Written comments may be submitted, in hard copy or electronic formats to:

Texas Department of Housing and Community Affairs

Attn: Andre Adams, Section 8 Manager

P.O. Box 13941

Austin, Texas 78711-3941

Email: andre.adams@tdhca.texas.gov

A public hearing will be held on November 19, 2024 beginning at 2:00 p.m. Central time and end at 3:00 p.m. at:

Texas Department of Housing and Community Affairs

221 E 11th Street, Room 129

Austin, Texas 78701

Written comments may be submitted in hard copy or email formats within the designated public comment period.

Those making public comment are encouraged to reference the specific draft rule, policy, or plan related to their comment as well as a specific reference or cite associated with each comment. Please be aware that all comments submitted to the TDHCA will be considered public information.

TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

Street Address: 221 East 11th Street, Austin, Texas 78701

Mailing Address: P.O. Box 13941, Austin, Texas 78711-3941

Main Number: (512) 475-3800 Toll Free: (800) 525-0657

Email: info@tdhca.texas.gov Web: www.tdhca.texas.gov

Propuesta aprobada por la Junta Directiva del Departamento de Vivienda y Asuntos Comunitarios de Texas del Plan Anual simplificado de la Autoridad de Vivienda Pública 2025

Comentario Público

Período de comentario público: Comienza: 8:00 a.m. del lunes 18 de noviembre de 2024

Finaliza: 5:00 p.m. del lunes 16 de diciembre de 2024

Comentarios recibidos después de las 5:00 p.m. el lunes 16 de diciembre de 2024 no serán aceptados.

Se pueden enviar comentarios por escrito, en copia impresa/fax o en formato electrónico a:

Departamento de Vivienda y Asuntos Comunitarios de Texas

A la atención de: Andre Adams, Gerente de la Sección 8

P.O. Box 13941

Austin, Texas 78711-3941

Correo electrónico: andre.adams@tdhca.texas.gov

Se llevará a cabo una audiencia pública el 19 de noviembre de 2024 a partir de las 2:00 p.m. y finalizará a las 3:00 p.m. en la siguiente dirección:

Departamento de Vivienda y Asuntos Comunitarios de Texas

221 E. 11th Street, Cuarto 129

Austin, Texas 78701

Los comentarios por escrito se pueden enviar en formato impreso o por correo electrónico dentro del período designado para comentarios públicos. Los que hagan comentarios públicos son animados a hacer referencia a la propuesta de regla, póliza, o plan específico relacionado con su comentario, así como a una referencia o cita específica asociada con cada comentario. Por favor tenga en cuenta que todos los comentarios enviados al Departamento de Vivienda y Asuntos Comunitarios de Texas se considerarán información pública.

DEPARTAMENTO DE VIVIENDA Y ASUNTOS COMUNITARIOS DE TEXAS

Dirección física: 221 East 11th Street, Austin, Texas 78701

Dirección de correspondencia: P.O. Box 13941, Austin, Texas 78711-3941

Número principal: (512) 475-3800 Número gratuito: (800) 525-0657

Correo electrónico: info@tdhca.texas.gov Página web: www.tdhca.texas.gov

TRD-202405220
Bobby Wilkinson
Executive Director
Texas Department of Housing and Community Affairs
Filed: October 31, 2024

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Texas Department of Insurance

Company Licensing

Application for incorporation in the state of Texas for Access to Care Health Plan, LLC, a domestic Health Maintenance Organization (HMO). The home office is in Austin, Texas.

Application to do business in the state of Texas for Immigrant Life Insurance Company of America, a foreign life, accident and/or health company. The home office is in Stamford, Connecticut.

Application for Consolidated National Insurance Company, a foreign fire and/or casualty company, to change its name to Drivers Edge Insurance Company. The home office is in Traverse City, Michigan.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of Andrew Guerrero, 1601 Congress Ave., Suite 6.900, Austin, Texas 78711.

TRD-202405354
Justin Beam
Chief Clerk
Texas Department of Insurance
Filed: November 6, 2024

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Legislative Budget Board

Tax Relief Amendment Implementation - Limit on Growth of Certain State Appropriations

LEGAL REFERENCES

The Texas Constitution, Article VIII, Section 22(a), restriction on the rate of growth of appropriations, commonly referred to as the tax spending limit, states that:

In no biennium shall the rate of growth of appropriations from state tax revenues not dedicated by this constitution exceed the estimated rate of growth of the state's economy. The legislature shall provide by general law procedures to implement this subsection.

This provision does not alter, amend, or repeal the Texas Constitution, Article III, Section 49a, known as the pay-as-you-go provision.

To implement this provision, Texas Government Code, Section 316.002 places the responsibility for approval of a limitation on the growth of certain state appropriations with the Legislative Budget Board. A part of the procedure for approving the limitation is set forth in Sections 316.003 and 316.004 as follows:

Section. 316.003. Before the Legislative Budget Board approves the items of information required by Section 316.002, the board shall publish in the *Texas Register* the proposed items of information and a description of the methodology and sources used in the calculations.

Section. 316.004. Not later than December 1 of each even-numbered year, the Legislative Budget Board shall hold a public hearing to solicit testimony regarding the proposed items of information and the methodology used in making the calculations required by Section 316.002.

These items of information are identified as follows in the Texas Government Code, Section 316.002:

1. the estimated rate of growth of the state's economy from the current biennium to the next biennium;

2. the level of appropriations for the current biennium from state tax revenues not dedicated by the constitution; and

3. the amount of state tax revenues not dedicated by the constitution that could be appropriated for the next biennium within the limit established by the estimated rate of growth of the state's economy.

In this memorandum, each item of information is discussed in this same order.

ESTIMATED RATE OF GROWTH OF THE STATE'S ECONOMY

A definition of the "estimated rate of growth of the state's economy" is set in the Texas Government Code, Section 316.002(b), in the following words:

(b) Except as provided by Subsection (c), the board shall determine the estimated rate of growth of the state's economy by dividing the estimated Texas total personal income for the next biennium by the estimated Texas total personal income for the current biennium. Using standard statistical methods, the board shall make the estimate by projecting through the biennium the estimated Texas total personal income reported by the United States Department of Commerce or its successor in function.

(c) If a more comprehensive definition of the rate of growth of the state's economy is developed and is approved by the committee established by Section 316.005, the board may use that definition in calculating the limit on appropriations.

The U.S. Commerce Department's Bureau of Economic Analysis defines state personal income as follows:

...the income received by persons from all sources, that is, from participation in production, from both government and business transfer payments, and from government interest. Personal income is the sum of wage and salary disbursements, supplements to wages and salaries, proprietors' income, rental income of persons, personal dividend income, personal interest income, and transfer payments, less contributions for social insurance.

Based on information from the U.S. Commerce Department's personal income account for Texas for calendar year 2023, the largest component of Texas personal income is wage and salary disbursements, estimated at $1,025.8 billion during calendar year 2023. Those salary and wage disbursements are then added with supplements to wages and salaries, primarily employer contributions to private pensions and welfare funds, and proprietors' income to arrive at total earnings by place of work. Texas' total earnings by place of work reached an estimated $1,454.9 billion in calendar year 2023. In deriving Texas' total personal income, adjustments are made to total earnings by place of work. Personal and employee contributions for social insurance, principally Social Security payroll taxes paid by employees and self-employed individuals, are deducted. A place-of-residence adjustment also is made to reflect the earnings of workers who cross state borders to live or work. Dividends, interest, and rent income are then added, along with transfer payments. The major types of transfer payments include Social Security, various retirement and unemployment insurance benefits, welfare, and disability and health insurance payments. Texas' total personal income is estimated to be $2,020.9 billion for calendar year 2023.

FORECASTING TEXAS PERSONAL INCOME

In reviewing standard statistical techniques for forecasting or projecting Texas personal income, the Legislative Budget Board has obtained the latest economic forecasts from the following sources, listed alphabetically: (1) Moody's Analytics, (2) Perryman Group, (3) S&P Global, and (4) Texas Comptroller of Public Accounts. These forecasts are based on econometric models developed and maintained by the forecasting services listed.

Tables 1 and 2 show details of the Texas personal income growth rates of the various forecasting services for the 2026-27 biennium over the 2024-25 biennium. These forecasts range from 10.98 percent to 12.20 percent.

The Legislative Budget Board is not limited to one, or any combination of the growth rates, when adopting a Texas personal income growth rate for the 2026-27 biennium.

APPROPRIATIONS FROM STATE TAX REVENUE NOT DEDICATED BY THE CONSTITUTION FOR THE 2024-25 BIENNIUM

The amount of appropriations from state tax revenue that are not dedicated by the constitution in the 2024-25 biennium, the base biennium, is the second item of information to be determined by the Legislative Budget Board. As of November 2024, the Legislative Budget Board (LBB) staff estimates this amount to be $110,262,478,661. This item multiplied by the estimated rate of growth of Texas personal income from the 2024-25 biennium to the 2026-27 biennium produces the limitation on appropriations for the 2026-27 biennium pursuant to the Texas Constitution, Article VIII, Section 22(a).

CALCULATING THE 2024-25 LIMITATION

The limitation on appropriations of state tax revenue that is not dedicated by the state constitution in the 2026-27 biennium, the third item of information, may be illustrated by selecting a growth rate and applying it to the 2024-25 biennial appropriations base. A change to the 2024-25 biennial appropriations base would result in a corresponding change to the 2026-27 biennial limit.

METHOD OF CALCULATING 2024-25 APPROPRIATIONS FROM STATE TAX REVENUE NOT DEDICATED BY THE CONSTITUTION

As previously stated, LBB staff estimates the amount of appropriations from state tax revenue that are not dedicated by the constitution in the 2024-2025 biennium to be $110,262,478,661. This section details the sources of information used in this calculation.

Total appropriations for the 2024-25 biennium include those made by the Eighty-eighth Legislature, Regular Session, 2023, in House Bill 1; by the Eighty-eighth Legislature, Third Called Session, 2023, in Senate Bill 3, and other legislation affecting appropriations. Any subsequent appropriations made by the Eighty-ninth Legislature, 2025, for the 2024-25 biennium also would be included in total appropriations. General Revenue Funds appropriations are financed with revenues in the following General Revenue Funds: General Revenue Fund (Fund No. 0001), Available School Fund (Fund No. 0002), Technology and Instructional Materials Fund (Fund No. 0003), Foundation School Fund (Fund No. 0193), and Tobacco Settlement Fund (Fund No. 5040).

General Revenue-Related appropriations are classified as either "estimated to be" line item appropriations or "sum certain" line item appropriations, and are adjusted for constitutionally dedicated General Revenue Related appropriations. Each "estimated to be" appropriation may be adjusted under certain circumstances. For purposes of this calculation, most fiscal year 2024 estimated appropriations are replaced with actual 2024 expenditures. Most amounts for fiscal year 2025 are taken from House Bill 1, Eighty-eighth Legislature, Regular Session, 2023.

The Eighty-eighth Legislature adopted, and voters approved several constitutional amendments that exempt certain appropriations from the tax spending limit, including:

House Bill 9 and House Joint Resolution 125, 88th Legislature Regular Session (appropriation) - $1.5 billion appropriated to the Broadband Infrastructure Fund;

Senate Bill 10 and House Joint Resolution 2, 88th Legislature Regular Session (appropriation) - $3.5 billion appropriation for a cost-of-living adjustment to certain Teacher Retirement System retirees;

Senate Bill 1648 and Senate Joint Resolution 74, 88th Legislature Regular Session (appropriation) - $1.0 billion appropriated Parks and Wildlife Department for deposit to the Centennial Parks Conservation Fund; and

Senate Bill 2 and House Joint Resolution 2, 88th Legislature Second Called Session (estimate) - Exempts appropriations for ad valorem tax relief. Exclusions for the purpose of paying for ad valorem tax relief are limited to those made after the adoption of the constitutional amendment in November 2023. Ad valorem tax relief amounts are therefore calculated relative to the tax base and tax rates as they existed in fiscal year 2023. As reflected in Section 18.79, Article IX, House Bill 1, Eighty-eighth Legislature, Regular Session, 2023, this estimated appropriation was split between General Revenue Related Funds ($5.3 billion) and the Property Tax Relief Fund (Fund No. 0304) ($12.3 billion).

Of the $129,267,071,599 of adjusted General Revenue Fund appropriations, $101,395,223,628 is subject to the limitation because it is financed from state tax revenue that is not dedicated by the Constitution. Constitutionally dedicated state tax revenues deposited into General Revenue Funds are estimated to total $9,309,747,707 during the 2024-25 biennium. Appropriations from General Revenue Funds financed from nontax revenue are estimated at $18,562,100,264 for the 2024-25 biennium. Revenue analysis in this calculation applies to actual fiscal year 2024 revenue collections and the most recent revenue estimates by the Comptroller of Public Accounts for fiscal year 2025.

Certain tax revenues are deposited into funds and accounts outside of the General Revenue Funds. Appropriations from these funds and accounts financed with state tax revenue that are not dedicated by the constitution are included in this calculation. The state imposes a sales and use tax on boats and boat motors, of which 95.0 percent is deposited into the General Revenue Funds and the remaining 5.0 percent is deposited into General Revenue-Dedicated Account No. 0009, Game, Fish, and Water Safety. The state imposes an insurance companies maintenance tax, which is deposited into General Revenue-Dedicated Account No. 0036, Texas Department of Insurance. A portion of the motor vehicles sales tax, franchise tax, and cigarette tax is deposited into the Property Tax Relief Fund (Fund No. 0304). Similarly, sales tax revenue collected by marketplace providers on the sales of taxable items made through the marketplace is deposited to the Tax Reduction and Excellence in Education Fund (Fund No. 0305). The state transfers revenue in the General Revenue Funds to the Economic Stabilization Fund (Fund No. 0599) based on the amount of severance tax collections during the previous year. Most of the transferred revenue is tax revenue. General Revenue-Dedicated Account No. 5066, Rural Volunteer Fire Department Insurance, includes deposits of taxes on the sales of fireworks. Part of the sales tax and the motor vehicles sales tax is deposited into General Revenue-Dedicated Account No. 5071, Emissions Reduction Plan. In addition, General Revenue-Dedicated Account No. 5144, Physician Education Loan Repayment, includes deposits of tobacco tax revenue. Senate Bill 30, Eighty-eighth Legislature, Regular Session, 2023, transferred $400,000,000 from the General Revenue Fund to General Revenue-Dedicated Account No. 5066, Deferred Maintenance. Appropriations from the account count against the tax spending limit to the same extent that appropriations from the General Revenue Fund count against the limit. As previously mentioned, the Eighty-eighth Legislature transferred $12,294,800,000 from the General Revenue Fund into the Property Tax Relief Fund (Fund No. 0304) and appropriated that amount as a method of finance for ad valorem tax relief in House Bill 1, Eighty-eighth Legislature, Regular Session, 2023. Additionally, the Eighty-eighth Legislature adopted, and voters approved a constitutional amendment creating the Texas Energy Fund (Fund No. 0176). The Eighty-eighth Legislature transferred $5,000,000,000 from the General Revenue Fund into the Texas Energy Fund and appropriated that amount to the Public Utility Commission in House Bill 1, Eighty-eighth Legislature, Regular Session, 2023. Money in the Texas Energy Fund is considered dedicated by the Constitution.

GRAND TOTAL

Combining the total General Revenue Related appropriations of $129,267,071,599 with the appropriations of funds outside of general revenue of $27,152,399,912, the 2024-25 biennial appropriations included in this analysis total $156,419,471,511. Of this amount, $26,604,547,707 is financed out of taxes dedicated by the state constitution, and $19,552,445,143 is financed out of nontax revenue. The remaining amount of $110,262,478,661 is financed out of state tax revenue that is not dedicated by the state constitution. This amount serves as the base for calculating the limitation on 2026-27 biennial appropriations from state tax revenue that is not dedicated by the constitution, as required by the Texas Constitution Article VIII, Section 22 (a). Any subsequent appropriations made by the Eighty-ninth Legislature, 2025, for the 2024-25 biennium could also be included in this amount.

IMPLEMENTATION OF THE LIMIT ON GROWTH OF CONSOLIDATED GENERAL REVENUE APPROPRIATIONS

LEGAL REFERENCES

The Texas Government Code, Chapter 316, also restricts the rate of growth of consolidated general revenue appropriations, referred to as the CGR limit. It states in Section 316.001(c) that:

"The rate of growth of consolidated general revenue appropriations in a state fiscal biennium may not exceed the estimated average biennial rate of growth of this state's population during the state fiscal biennium preceding the biennium for which appropriations are made and during the state fiscal biennium for which appropriations are made, adjusted by the estimated average biennial rate of monetary inflation in this state during the same period..."

This provision does not alter, amend, or repeal the Texas Constitution, Article III, Section 49a limit, referred to as the pay-as-you-go provision, or the Texas Constitution, Article VIII, Section 22 limit, referred to as the tax spending limit.

Texas Government Code, Section 316.002 places with the Legislative Budget Board the responsibility for the approval of this limitation on the growth of consolidated general revenue appropriations. Specifi-

cally, the items of information related to the CGR limit that require approval are identified as follows:

4. the limit on the rate of growth of consolidated general revenue appropriations for that state fiscal biennium, as compared to the previous state fiscal biennium;

5. the estimated average biennial rate of growth of this state's population during the state fiscal biennium preceding the biennium for which appropriations are made and during the state fiscal biennium for which appropriations are made;

6. the estimated average biennial rate of monetary inflation during the state fiscal biennium preceding the biennium for which appropriations are made and during the state fiscal biennium for which appropriations are made;

7. the level of consolidated general revenue appropriations for the current state fiscal biennium; and

8. the limit on the amount of consolidated general revenue appropriations that could be appropriated for the next state fiscal biennium.

LIMIT ON THE RATE OF GROWTH OF CONSOLIDATED GENERAL REVENUE APPROPRIATIONS

The methodology for calculating the limit on the rate of growth for the CGR limit is set in the Texas Government Code, Section 316.002(a)(2), in the following words:

(2) the limit on the rate of growth of consolidated general revenue appropriations for that state fiscal biennium, as compared to the previous state fiscal biennium, by subtracting one from the product of:

(A) the sum of one and the estimated average biennial rate of growth of this state's population during the state fiscal biennium preceding the biennium for which appropriations are made and during the state fiscal biennium for which appropriations are made; and

(B) the sum of one and the estimated average biennial rate of monetary inflation during the state fiscal biennium preceding the biennium for which appropriations are made and during the state fiscal biennium for which appropriations are made.

Mathematically, the formula described by the statute looks like:

$$CGR\ growth\ rate = \left(\left(1 + \frac{p_t + p_{t+1}}{2}\right) * \left(1 + \frac{i_t + i_{t+1}}{2}\right)\right) - 1$$

$$p_t = biennial\ Texas\ population\ growth\ rate\ for\ current\ biennium$$

$$p_{t+1} = biennial\ Texas\ population\ growth\ rate\ for\ upcoming\ biennium$$

$$i_t = biennial\ monetary\ inflation\ growth\ rate\ for\ current\ biennium$$

$$i_{t+1} = biennial\ monetary\ inflation\ growth\ rate\ for\ upcoming\ biennium$$

ESTIMATED RATE OF TEXAS POPULATION GROWTH

The statute does not specifically define the state's population, rather Texas Government Code, Section 316.001(e) directs the LBB to determine the rate of growth of the state's population as follows:

(e) The Legislative Budget Board shall determine the rates described by Subsection (c) using the most recent information available from sources the board considers reliable, including the United States Bureau of Labor Statistics Consumer Price Index and the Texas Demographic Center.

The U.S. Census Bureau defines the state's population as follows:

The resident population includes all people currently residing in the state on a specific date. The population estimate at any given time point starts with a population base (e.g. the last decennial census or the previous point in the time series), adds births, subtracts deaths, and adds net migration (both international and domestic).

The Texas Demographic Center was initiated in 1980 to establish a state level liaison to the U.S. Census Bureau for better dissemination of Texas census data. In the mid-1980s, the Texas Population Estimates and Projections Program was established with the overall objective of providing annual estimates of the population of Texas counties and places and biennial projections of the population of the state and counties.

ESTIMATED RATE OF MONETARY INFLATION

The statute does not specifically define monetary inflation, rather Texas Government Code, Section 316.001(e) directs the LBB to determine the rate of monetary inflation as follows:

(e) The Legislative Budget Board shall determine the rates described by Subsection (c) using the most recent information available from sources the board considers reliable, including the United States Bureau of Labor Statistics Consumer Price Index and the Texas Demographic Center.

The U.S. Bureau of Labor Statistics defines the Consumer Price Index as follows:

The **Consumer Price Index (CPI)** is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. Indexes are available for the U.S. and various geographic areas. Average price data for select utility, automotive fuel, and food items are also available. Prices for the goods and services used to calculate the CPI are collected in 75 urban areas throughout the country and from about 23,000 retail and service establishments. Data on rents are collected from about 50,000 landlords or tenants. The weight for an item is derived from reported expenditures on that item as estimated by the Consumer Expenditure Survey.

The U.S. Bureau of Labor Statistic's reports the Consumer Price Index monthly. Because the state's fiscal year begins on September 1 and ends August 31, an adjustment is required to present these data on a biennial basis. The Legislative Budget Board uses the average of the Consumer Price Index over the 24 months of a biennium to represent the rate of monetary inflation during the state's fiscal biennium.

FORECASTING TEXAS POPULATION AND MONETARY INFLATION

In reviewing standard statistical techniques for forecasting or projecting Texas population and monetary inflation, the Legislative Budget Board has obtained the latest economic forecasts from the following sources, listed alphabetically: (1) Moody's Analytics, (2) Perryman Group, (3) S&P Global, and (4) Texas Comptroller of Public Accounts. These forecasts are based on econometric models developed and maintained by the forecasting services listed. In addition, the Legislative Budget Board has obtained the most recent population projections from the Texas Demographic Center.

Tables 3 and 4 show details of the Texas population and monetary inflation growth rates of the various forecasting services for the average of the 2026-27 biennium over the 2024-25 biennium and the 2024-25 biennium over the 2022-23 biennium. These forecasts range from 2.48 percent to 3.52 percent for Texas population and from 5.88 percent to 6.55 percent for monetary inflation.

The Legislative Budget Board is not limited to one, or any combination of the growth rates, when adopting a Texas population growth rate or monetary inflation growth rate for the 2026-27 biennium.

CONSOLIDATED GENERAL REVENUE APPROPRIATIONS FOR THE 2024-25 BIENNIUM

The amount of consolidated general revenue appropriations in the 2024-25 biennium, the base biennium, is the fourth item of information to be determined by the Legislative Budget Board. As of November 2024, the Legislative Budget Board (LBB) staff estimates this amount to be $147,392,369,786.

Texas Government Code, Section 316.001 (a) defines "consolidated general revenue appropriations" as follows:

(a) For purposes of this subchapter, "consolidated general revenue appropriations" means appropriations from:

(1) the general revenue fund in the state treasury;

(2) a dedicated account in the general revenue fund in the state treasury; or

(3) a general revenue-related fund in the state treasury as identified in the biennial statement required of the comptroller under Section 49a, Article III, Texas Constitution.

Similar to the tax spending limit referenced above, General Revenue-Related appropriations are classified as either "estimated to be" line item appropriations or "sum certain" line item appropriations. Each "estimated to be" appropriation may be adjusted under certain circumstances. For purposes of this calculation, most fiscal year 2024 estimated appropriations are replaced with actual 2024 expenditures. Most amounts for fiscal year 2025 are taken from the House Bill 1 and House Bill 4041, Eighty-eighth Legislature, Regular Session, 2023; and Senate Bill 3, Eighty-eighth Legislature, Fourth Called Session, 2023, and other legislation affecting appropriations. Additionally, adjustments were made to account for appropriations triggered by changes in revenue compared to forecast, vetoed appropriations, and appropriations contingent on legislation that did not pass.

EXCLUSIONS FROM THE 2024-25 CONSOLIDATED GENERAL REVENUE BASE

Texas Government Code, Section 316.001(d) states that two types of appropriations are to be excluded from the computation of consolidated general revenue appropriations:

(d) For purposes of this subchapter, the following appropriations must be excluded from computations used to determine whether appropriations exceed the amount authorized by Subsection (c):

(1) an appropriation for a purpose that provides tax relief; or

(2) an appropriation to pay costs associated with recovery from a disaster declared by the governor under Section 418.014.

Exclusions for a purpose that provides tax relief are limited to those made beginning with the 2024-25 biennium, the first biennium the consolidated general revenue limit was implemented. Tax relief amounts are therefore relative to the tax base and tax rates as they existed in fiscal year 2023. General revenue exclusions for property tax relief include those made in Article IX, Sec. 18.79 of the GAA (House Bill 1, Eighty-eighth Legislature, Regular Session, 2023), as well as Senate Bill 2 and House Joint Resolution 2, Eighty-eighth Legislature, Second Called Session, 2023, and House Bill 3, Eighty-sixth Legislature, Regular Session, 2019. Exclusions for governor-declared disaster appropriations include appropriations for border security initiatives, as well as those appropriations made to several agencies to respond to other, primarily natural, disasters. As of November 2024, the Legislative Budget Board (LBB) staff estimates $12,458,207,524 is excluded from the computation of consolidated general revenue appropriations for the 2024-25 biennium.

Any subsequent consolidated general revenue appropriations made by the Eighty-ninth Legislature, 2025, for the 2024-25 biennium also would be included in total appropriations.

ADJUSTED CONSOLIDATED GENERAL REVENUE APPROPRIATIONS FOR THE 2024-25 BIENNIUM

The 2024-25 consolidated general revenue appropriations total $134,934,162,262. This amount serves as the base for calculating the limitation on 2026-27 consolidated general revenue appropriations as required by the Texas Government Code, Section 316.001. This item multiplied by the average estimated rate of growth of Texas population and monetary inflation from the 2022-23 biennium to the 2024-25 biennium and the 2024-25 biennium to the 2026-27 biennium produces the limitation on consolidated general revenue appropriations for the 2026-27 biennium.

CALCULATING THE 2026-27 LIMITATION

The limitation on consolidated general revenue appropriations in the 2026-27 biennium, the fifth item of information, may be illustrated by selecting a growth rate, adding one, and multiplying it by the 2024-25 adjusted biennial general revenue appropriations base. Any changes to the 2024-25 adjusted biennial general revenue appropriations base would result in a corresponding change to the 2026-27 biennial limit.

TABLE 1

ESTIMATED GROWTH RATES FOR TEXAS PERSONAL INCOME

2024-25 BIENNIUM TO 2026-27 BIENNIUM

Source of Forecast	2026-27 Texas Personal Income Growth Rate
1. Moody's Analytics	10.98%
2. Perryman Group	11.48%
3. S&P Global	11.37%
4. Texas Comptroller of Public Accounts	12.20%

TABLE 2

SUMMARY OF SOURCES AND METHODS FOR

TEXAS PERSONAL INCOME GROWTH RATES FOR THE 2026-27 BIENNIUM

Source of Forecast	Type of Forecast	Date of Forecast
1. Moody's Analytics	Econometric	October 2024
2. Perryman Group	Econometric	October 2024
3. S&P Global	Econometric	October 2024
4. Texas Comptroller of Public Accounts	Econometric	October 2024

Source: Compiled by the Legislative Budget Board, October 2024

TABLE 3

ESTIMATED GROWTH RATES FOR CPI AND TEXAS POPULATION

2023-23 TO 2024-25 BIENNIA AVERAGED WITH 2024-25 TO 2026-27 BIENNIA

Source of Forecast	AVG 24-25 and 26-27 CPI Growth Rate
1. Moody's Analytics	5.90%
2. Perryman Group	6.55%
3. S&P Global	5.92%
4. Texas Comptroller of Public Accounts	5.88%

Source of Forecast	AVG 24-25 and 26-27 Texas Population Growth Rate
1. Moody's Analytics	3.45%
2. Perryman Group	3.12%
3. S&P Global	3.52%
4. Texas Comptroller of Public Accounts	2.50%
5. Texas Demographic Center (1.0 Scenario)	2.48%

Note: The Texas Demographic Center Vintage 2022 Projection's 1.0 Scenario assumes the continuation of migration rates between 2010-2020. Moody's Analytics, S&P Global, and the Comptroller of Public Accounts inflation forecast is based on the U.S. Consumer Price Index. The Perryman Group's inflation forecast is based on the Texas Consumer Price Index.

Source: Compiled by the Legislative Budget Board, October 2024

TABLE 4

SUMMARY OF SOURCES AND METHODS FOR

CONSUMER PRICE INDEX AND TEXAS POPULATION GROWTH RATES

FOR THE 2026-27 BIENNIUM

Source of Forecast	Type of Forecast	Date of Forecast
1. Moody's Analytics	Econometric	October 2024
2. Perryman Group	Econometric	October 2024
3. S&P Global	Econometric	October 2024
4. Texas Comptroller of Public Accounts	Econometric	October 2024
5. Texas Demographic Center	Projection	October 2024

Source: Compiled by the Legislative Budget Board, October 2024

TRD-202405330
Stewart Shallow
General Counsel
Legislative Budget Board
Filed: November 6, 2024

♦ ♦ ♦

Texas Lottery Commission

Notice of Public Comment Hearing

A public hearing to receive comments regarding the proposed repeal of existing 16 TAC §§402.301 (Bingo Card/Paper) and 402.303 (Pull-tab or Instant Bingo Dispensers); the addition of new 16 TAC §§402.105 (Postmarks, Timely Filing of Forms, Reports, Applications and Payment of Taxes and Fees), 402.301 (Approval of Pull-Tab Bingo Tickets), 402.302 (Pull-Tab Bingo Manufacturing Requirements), 402.303 (Pull-Tab Bingo Sales and Redemption), 402.304 (Pull-Tab Bingo Record Keeping), 402.305 (Pull-Tab Bingo Styles of Play), 402.306 (Bingo Card/Paper Definitions), 402.307 (Bingo Card/Paper Approval), 402.308 (Bingo Card/Paper Manufacturing Requirements), 402.309 (Bingo Card/Paper Record Keeping), 402.310 (Bingo Card/Paper Styles of Play), and 402.311 (Pull-Tab or Instant Bingo Dispensers); and amendments to 16 TAC §§402.100 (Definitions), 402.101 (Advisory Opinions), 402.102 (Bingo Advisory Committee), 402.103 (Training Program), 402.200 (General Restrictions on the Conduct of Bingo), 402.201 (Prohibited Bingo Occasion), 402.202 (Transfer of Funds), 402.203 (Unit Accounting), 402.210 (House Rules), 402.212 (Promotional Bingo), 402.300 (Pull-Tab Bingo), 402.324 (Card-Minding Systems--Approval of Card-Minding Systems), 402.325 (Card-Minding Systems--Licensed Authorized Organizations Requirements), 402.326 (Card-Minding Systems--Distributor Requirements), 402.334 (Shutter Card Bingo Systems - Approval of Shutter Card Bingo Systems), 402.400 (General Licensing Provisions), 402.401 (Temporary License), 402.402 (Registry of Bingo Workers), 402.404 (License Classes and Fees), 402.411 (License Renewal), 402.443 (Transfer of a Grandfathered Lessor's Commercial Lessor License), 402.500 (General Records Requirements), 402.502 (Charitable Use of Net Proceeds Recordkeeping), 402.600 (Bingo Reports and Payments), 402.601 (Interest on Delinquent Tax), 402.602 (Waiver of Penalty, Settlement of Prize Fees, Penalty and/or Interest), 402.702 (Disqualifying Convictions), 402.703 (Audit Policy), 402.706 (Schedule of Sanctions), and 402.707 (Expedited Administrative Penalty Guideline) will be held on Wednesday, December 4, 2024 at 1:00 p.m., at 1801 Congress Ave., Austin, Texas 78701, George H. W. Bush Building, 4th Floor, Board Room 4.300.

Persons requiring any accommodation for disability should notify Dorota Bienkowska at (512) 344-5392 or dorota.bienkowska@lottery.state.tx.us at least 72 hours prior to the public hearing.

TRD-202405231

Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 1, 2024

Scratch Ticket Game Number 2616 "30X SUPREME"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2616 is "30X SUPREME". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2616 shall be $30.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2616.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: STAR SYMBOL, HEART SYMBOL, MOON SYMBOL, COIN SYMBOL, RAINBOW SYMBOL, ELEPHANT SYMBOL, WISHBONE SYMBOL, WALLET SYMBOL, SUN SYMBOL, GOLD BAR SYMBOL, HORSESHOE SYMBOL, ANCHOR SYMBOL, SAILBOAT SYMBOL, LIGHTNING BOLT SYMBOL, DICE SYMBOL, SHELL SYMBOL, CROWN SYMBOL, UMBRELLA SYMBOL, WALNUT SYMBOL, DAISY SYMBOL, HAT SYMBOL, BOOT SYMBOL, BIRD SYMBOL, LADYBUG SYMBOL, BUTTERFLY SYMBOL, PIGGY BANK SYMBOL, STACK OF CASH SYMBOL, POT OF GOLD SYMBOL, RING SYMBOL, RUBY SYMBOL, 3X SYMBOL, 5X SYMBOL, 10X SYMBOL, 30X SYMBOL, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, $30.00, $50.00, $100, $150, $200, $300, $500, $1,000, $10,000 and $3,000,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2616 - 1.2D

PLAY SYMBOL	CAPTION
STAR SYMBOL	STAR
HEART SYMBOL	HEART
MOON SYMBOL	MOON
COIN SYMBOL	COIN
RAINBOW SYMBOL	RAINBW
ELEPHANT SYMBOL	ELEPHT
WISHBONE SYMBOL	WSHBNE
WALLET SYMBOL	WALLET
SUN SYMBOL	SUN
GOLD BAR SYMBOL	BAR
HORSESHOE SYMBOL	HRSHOE
ANCHOR SYMBOL	ANCHOR
SAILBOAT SYMBOL	BOAT
LIGHTNING BOLT SYMBOL	BOLT
DICE SYMBOL	DICE
SHELL SYMBOL	SHELL
CROWN SYMBOL	CROWN
UMBRELLA SYMBOL	UMBRLA
WALNUT SYMBOL	WALNUT
DAISY SYMBOL	DAISY
HAT SYMBOL	HAT
BOOT SYMBOL	BOOT
BIRD SYMBOL	BIRD
LADYBUG SYMBOL	LDYBUG
BUTTERFLY SYMBOL	BTRFLY
PIGGY BANK SYMBOL	PIGBNK
STACK OF CASH SYMBOL	CASH

POT OF GOLD SYMBOL	GOLD
RING SYMBOL	RING
RUBY SYMBOL	RUBY
3X SYMBOL	TRP
5X SYMBOL	WINX5
10X SYMBOL	WINX10
30X SYMBOL	WINX30
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET

29	TWNI
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
46	FRSX
47	FRSV
48	FRET
49	FRNI
50	FFTY
51	FFON
52	FFTO
53	FFTH
54	FFFR
55	FFFV
$30.00	TRTY$
$50.00	FFTY$
$100	ONHN

$150	ONFF
$200	TOHN
$300	THHN
$500	FVHN
$1,000	ONTH
$10,000	10TH
$3,000,000	TPPZ

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2616), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 025 within each Pack. The format will be: 2616-0000001-001.

H. Pack - A Pack of the "30X SUPREME" Scratch Ticket Game contains 025 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The front of Ticket 001 will be shown on the front of the Pack; the back of Ticket 025 will be revealed on the back of the Pack. All Packs will be tightly shrink-wrapped. There will be no breaks between the Tickets in a Pack. Every other Pack will reverse i.e., reverse order will be: the back of Ticket 001 will be shown on the front of the Pack and the front of Ticket 025 will be shown on the back of the Pack.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - Texas Lottery "30X SUPREME" Scratch Ticket Game No. 2616.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "30X SUPREME" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose eighty-four (84) Play Symbols. BONUS PLAY AREAS PLAY INSTRUCTIONS: $30 BONUS: If the player reveals 3 matching Play Symbols in the $30 BONUS, the player wins $30. $50 BONUS: If the player reveals 3 matching Play Symbols in the $50 BONUS, the player wins $50. $100 BONUS: If the player reveals 3 matching Play Symbols in the $100 BONUS, the player wins $100. $200 BONUS: If the player reveals 3 matching Play Symbols in the $200 BONUS, the player wins $200. $300 BONUS: If the player reveals 3 matching Play Symbols in the $300 BONUS, the player wins $300. $500 BONUS: If the player reveals 3 matching Play Symbols in the $500 BONUS, the player wins $500. 30X SUPREME PLAY INSTRUCTIONS: If the player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "3X" Play Symbol, the player wins TRIPLE the prize for that symbol. If the player reveals a "5X" Play Symbol, the player wins 5 TIMES the prize for that symbol. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the player reveals a "30X" Play Symbol, the player wins 30 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly eighty-four (84) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly eighty-four (84) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the eighty-four (84) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the eighty-four (84) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

B. GENERAL: A Ticket can win as indicated by the prize structure.

C. GENERAL: A Ticket can win up to thirty-six (36) times.

D. GENERAL: The "3X" (TRP), "5X" (WINX5), "10X" (WINX10) and "30X" (WINX30) Play Symbols will never appear in any of the BONUS play areas.

E. $30 BONUS: A non-winning $30 BONUS play area will have two (2) or three (3) different Play Symbols.

F. $30 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $30 BONUS play area and will win $30.

G. $50 BONUS: A non-winning $50 BONUS play area will have two (2) or three (3) different Play Symbols.

H. $50 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $50 BONUS play area and will win $50.

I. $100 BONUS: A non-winning $100 BONUS play area will have two (2) or three (3) different Play Symbols.

J. $100 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $100 BONUS play area and will win $100.

K. $200 BONUS: A non-winning $200 BONUS play area will have two (2) or three (3) different Play Symbols.

L. $200 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $200 BONUS play area and will win $200.

M. $300 BONUS: A non-winning $300 BONUS play area will have two (2) or three (3) different Play Symbols.

N. $300 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $300 BONUS play area and will win $300.

O. $500 BONUS: A non-winning $500 BONUS play area will have two (2) or three (3) different Play Symbols.

P. $500 BONUS: Winning Tickets will contain three (3) matching Play Symbols in the $500 BONUS play area and will win $500.

Q. 30X SUPREME: This game can win up to thirty (30) times.

R. 30X SUPREME: A non-winning Prize Symbol will never match a winning Prize Symbol.

S. 30X SUPREME: On winning and Non-Winning Tickets, the top cash prizes of $1,000, $10,000 and $3,000,000 will each appear at least one (1) time, except on Tickets winning thirty-six (36) times and with respect to other parameters, play action or prize structure.

T. 30X SUPREME: No matching non-winning YOUR NUMBERS Play Symbols will appear on a Ticket.

U. 30X SUPREME: Tickets winning more than one (1) time will use as many WINNING NUMBERS Play Symbols as possible to create matches, unless restricted by other parameters, play action or prize structure.

V. 30X SUPREME: No matching WINNING NUMBERS Play Symbols will appear on a Ticket.

W. 30X SUPREME: All YOUR NUMBERS Play Symbols, excluding the "3X" (TRP), "5X" (WINX5), "10X" (WINX10) and "30X" (WINX30) Play Symbols, will never equal the corresponding Prize Symbol (i.e., 50 and $50).

X. 30X SUPREME: On all Tickets, a Prize Symbol will not appear more than four (4) times, except as required by the prize structure to create multiple wins.

Y. 30X SUPREME: On Non-Winning Tickets, a WINNING NUMBERS Play Symbol will never match a YOUR NUMBERS Play Symbol.

Z. 30X SUPREME: The "3X" (TRP) Play Symbol will never appear more than one (1) time on a Ticket.

AA. 30X SUPREME: The "3X" (TRP) Play Symbol will win TRIPLE the prize for that Play Symbol and will win as per the prize structure.

BB. 30X SUPREME: The "3X" (TRP) Play Symbol will never appear on a Non-Winning Ticket.

CC. 30X SUPREME: The "3X" (TRP) Play Symbol will never appear as a WINNING NUMBERS Play Symbol.

DD. 30X SUPREME: The "5X" (WINX5) Play Symbol will never appear more than one (1) time on a Ticket.

EE. 30X SUPREME: The "5X" (WINX5) Play Symbol will win 5 TIMES the prize for that Play Symbol and will win as per the prize structure.

FF. 30X SUPREME: The "5X" (WINX5) Play Symbol will never appear on a Non-Winning Ticket.

GG. 30X SUPREME: The "5X" (WINX5) Play Symbol will never appear as a WINNING NUMBERS Play Symbol.

HH. 30X SUPREME: The "10X" (WINX10) Play Symbol will never appear more than one (1) time on a Ticket.

II. 30X SUPREME: The "10X" (WINX10) Play Symbol will win 10 TIMES the prize for that Play Symbol and will win as per the prize structure.

JJ. 30X SUPREME: The "10X" (WINX10) Play Symbol will never appear on a Non-Winning Ticket.

KK. 30X SUPREME: The "10X" (WINX10) Play Symbol will never appear as a WINNING NUMBERS Play Symbol.

LL. 30X SUPREME: The "30X" (WINX30) Play Symbol will never appear more than one (1) time on a Ticket.

MM. 30X SUPREME: The "30X" (WINX30) Play Symbol will win 30 TIMES the prize for that Play Symbol and will win as per the prize structure.

NN. 30X SUPREME: The "30X" (WINX30) Play Symbol will never appear on a Non-Winning Ticket.

OO. 30X SUPREME: The "30X" (WINX30) Play Symbol will never appear as a WINNING NUMBERS Play Symbol.

PP. 30X SUPREME: No two (2) different multiplier Play Symbols can appear on the same Ticket, with the exception of the "3X" (TRP) and "10X" (WINX10) Play Symbols, which can only appear together as per the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "30X SUPREME" Scratch Ticket Game prize of $30.00, $50.00, $100, $150, $200, $300 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $30.00, $50.00, $100, $150, $200, $300 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "30X SUPREME" Scratch Ticket Game prize of $1,000, $1,500 or $10,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. To claim a "30X SUPREME" Scratch Ticket Game top level prize of $3,000,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers in Austin, Dallas, Fort Worth, Houston or San Antonio, Texas. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification and proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). The Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. As an alternative method of claiming a "30X SUPREME" Scratch Ticket Game prize, including the top level prize of $3,000,000, the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

E. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

F. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "30X SUPREME" Scratch Ticket Game, the Texas Lottery shall deliver to

an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "30X SUPREME" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Prizes. There will be approximately 7,080,000 Scratch Tickets in Scratch Ticket Game No. 2616. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2616 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$30.00	708,000	10.00
$50.00	424,800	16.67
$100	495,600	14.29
$150	135,700	52.17
$200	43,660	162.16
$300	64,900	109.09
$500	10,030	705.88
$1,000	1,160	6,103.45
$1,500	150	47,200.00
$10,000	30	236,000.00
$3,000,000	4	1,770,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.76. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2616 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the

closing date and reasons for closing will be made in accordance with the Scratch Ticket closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2616, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405335
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2617 "$5,000 BLITZ"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2617 is "$5,000 BLITZ". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. Tickets for Scratch Ticket Game No. 2617 shall be $1.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2617.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 01, 02, 03, 04, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 5X SYMBOL, 10X SYMBOL, 20X SYMBOL, $1.00, $2.00, $3.00, $5.00, $10.00, $20.00, $40.00, $100, $500 and $5,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2617 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
02	TWO
03	THR
04	FOR
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
5X SYMBOL	WINX5
10X SYMBOL	WINX10
20X SYMBOL	WINX20
$1.00	ONE$
$2.00	TWO$
$3.00	THR$
$5.00	FIV$
$10.00	TEN$
$20.00	TWY$
$40.00	FRTY$
$100	ONHN
$500	FVHN
$5,000	FVTH

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2617), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 150 within each Pack. The format will be: 2617-0000001-001.

H. Pack - A Pack of "$5,000 BLITZ" Scratch Ticket Game contains 150 Scratch Tickets, packed in plastic shrink-wrapping and fanfolded in pages of five (5). Tickets 001 to 005 will be on the top page; Tickets 006 to 010 on the next page; etc.; and Tickets 146 to 150 will be on the last page with backs exposed. Ticket 001 will be folded over so the front of Ticket 001 and 010 will be exposed.

I. Non-Winning Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - A Texas Lottery "$5,000 BLITZ" Scratch Ticket Game No. 2617.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$5,000 BLITZ" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose eleven (11) Play Symbols. If a player matches any of the YOUR NUMBERS Play Symbols to the WINNING NUMBER Play Symbol, the player wins the prize for that number. If the player reveals a "5X" Play Symbol, the player wins 5 TIMES the prize for that symbol. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the player reveals a "20X" Play Symbol, the player wins 20 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly eleven (11) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly eleven (11) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the eleven (11) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the eleven (11) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: A Ticket can win up to five (5) times in accordance with the prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

D. KEY NUMBER MATCH: Each Ticket will have one (1) WINNING NUMBER Play Symbol.

E. KEY NUMBER MATCH: Non-winning YOUR NUMBERS Play Symbols will all be different.

F. KEY NUMBER MATCH: Non-winning Prize Symbols will never appear more than one (1) time on a Ticket.

G. KEY NUMBER MATCH: The "5X" (WINX5), "10X" (WINX10) and "20X" (WINX20) Play Symbols will never appear in the WINNING NUMBER Play Symbol spot.

H. KEY NUMBER MATCH: The "5X" (WINX5), "10X" (WINX10) and "20X" (WINX20) Play Symbols will only appear on winning Tickets as dictated by the prize structure.

I. KEY NUMBER MATCH: Non-winning Prize Symbols will never be the same as the winning Prize Symbol(s).

J. KEY NUMBER MATCH: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 03 and $3).

2.3 Procedure for Claiming Prizes.

A. To claim a "$5,000 BLITZ" Scratch Ticket Game prize of $1.00, $2.00, $3.00, $5.00, $10.00, $20.00, $40.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $40.00, $100 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$5,000 BLITZ" Scratch Ticket Game prize of $5,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$5,000 BLITZ" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 14 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$5,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$5,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any Non-Winning "$5,000 BLITZ" Scratch Ticket may be entered into one (1) of five (5) promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Scratch Ticket for information on eligibility and entry requirements.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 25,200,000 Scratch Tickets in the Scratch Ticket Game No. 2617. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2617 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$1.00	2,352,000	10.71
$2.00	1,386,000	18.18
$3.00	420,000	60.00
$5.00	924,000	27.27
$10.00	126,000	200.00
$20.00	84,000	300.00
$40.00	11,235	2,242.99
$100	2,835	8,888.89
$500	48	525,000.00
$5,000	6	4,200,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.75. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2617 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2617, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405337

Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2618 "$60,000 BLITZ WORD SEARCH"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2618 is "$60,000 BLITZ WORD SEARCH". The play style is "other".

1.1 Price of Scratch Ticket Game.

A. Tickets for Scratch Ticket Game No. 2618 shall be $3.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2618.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, 2X SYMBOL, 3X SYMBOL, 5X SYMBOL, 30X SYMBOL, $3.00, $5.00, $10.00, $15.00, $20.00, $30.00, $45.00, $90.00, $150, $300, $2,000 and $60,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. Crossword and Bingo style games do not typically have Play Symbol captions. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2618 - 1.2D

PLAY SYMBOL	CAPTION
A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	
U	
V	
W	
X	
Y	

Z	
2X SYMBOL	DBL
3X SYMBOL	TRP
5X SYMBOL	WINX5
30X SYMBOL	WINX30
$3.00	THR$
$5.00	FIV$
$10.00	TEN$
$15.00	FFN$
$20.00	TWY$
$30.00	TRTY$
$45.00	FRFV$
$90.00	NITY$
$150	ONFF
$300	THHN
$2,000	TOTH
$60,000	60TH

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2618), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 125 within each Pack. The format will be: 2618-0000001-001.

H. Pack - A Pack of "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game contains 125 Scratch Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be 2 fanfold configurations for this game. Configuration A will show the front of Ticket 001 and the back of Ticket 125. Configuration B will show the back of Ticket 001 and the front of Ticket 125.

I. Non-Winning Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - A Texas Lottery "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game No. 2618.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose the Play Symbols as indicated per the game instructions from the total of seventy-eight (78) Play Symbols. GAMES 1 - 10 PLAY INSTRUCTIONS: 1. The player completely scratches all of the YOUR 18 LETTERS Play Symbols. 2. The player then scratches all of the letters found in GAMES 1 - 10 that exactly match the YOUR 18 LETTERS Play Symbols. 3. If the player

matches all the letters in the same GAME with the YOUR 18 LETTERS Play Symbols, the player wins the PRIZE for that GAME. MULTIPLIER PLAY INSTRUCTIONS: The player scratches the MULTIPLIER play area to reveal 2 MULTIPLIER Play Symbols. If the player reveals 2 matching MULTIPLIER Play Symbols, the player multiplies the total prize won in GAMES 1 - 10 by that multiplier and wins that amount. For example, revealing 2 "30X" MULTIPLIER Play Symbols will multiply the total prize won by 30 TIMES. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly seventy-eight (78) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption. Crossword and Bingo style games do not typically have Play Symbol captions;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly seventy-eight (78) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the seventy-eight (78) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the seventy-eight (78) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: A Ticket can win up to four (4) times in accordance with the prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

D. GENERAL: Each Ticket consists of a YOUR 18 LETTERS play area, a GAMES 1 - 10 play area and a MULTIPLIER play area.

E. YOUR 18 LETTERS: Each letter will appear once per Ticket in the YOUR 18 LETTERS play area.

F. YOUR 18 LETTERS: There will be a minimum of three (3) vowels in the YOUR 18 LETTERS play area. Vowels are A, E, I, O and U.

G. YOUR 18 LETTERS: A player will never find a word horizontally (in any direction), vertically (in any direction) or diagonally (in any direction) in the YOUR 18 LETTERS play area that matches a word in GAMES 1 - 10.

H. YOUR 18 LETTERS: A minimum of fourteen (14) YOUR 18 LETTERS will open at least one (1) letter in GAMES 1 - 10.

I. YOUR 18 LETTERS: None of the words from the TX_Prohibited_Words_Vers.2.042321.docx will appear horizontally, vertically or diagonally (in any direction) in the YOUR 18 LETTERS play area.

J. YOUR 18 LETTERS: The words "VD" and "ED" will not be presented in a row horizontally or diagonally in the YOUR 18 LETTERS play area.

K. GAMES 1 - 10: Each word will appear only once per Ticket in GAMES 1 - 10.

L. GAMES 1 - 10: The length of the words found in GAMES 1 - 10 will range from three (3) to seven (7) letters, as shown on the artwork.

M. GAMES 1 - 10: The $3 and $5 Prize Symbols will only appear in GAMES 3 - 10. The $150 and $300 Prize Symbols will only appear

in GAMES 1 - 7. The $2,000 and $60,000 Prize Symbols will only appear in GAMES 1 - 4.

N. GAMES 1 - 10: Only words from the approved word list (TX_Approved_Words_Vers.2.042321.doc) will appear in GAMES 1 - 10.

O. GAMES 1 - 10: None of the words from the TX_Prohibited_Words_Vers.2.042321.docx will appear vertically or diagonally (in any direction) in GAMES 1 - 10.

P. GAMES 1 - 10: The $10.00, $15.00, $20.00, $30.00, $45.00 and $90.00 Prize Symbols can appear in GAMES 1 - 10.

Q. MULTIPLIER: The "2X" (DBL), "3X" (TRP), "5X" (WINX5) and "30X" (WINX30) Play Symbols will only appear in the MULTIPLIER play area and will never appear in the GAMES 1 - 10 or YOUR 18 LETTERS play areas.

R. MULTIPLIER: Two (2) matching MULTIPLIER Play Symbols of "2X" (DBL), "3X" (TRP), "5X" (WINX5) or "30X" (WINX30) will only appear on winning Tickets, as dictated by the prize structure.

S. MULTIPLIER: Tickets that do not win in the MULTIPLIER play area will display two (2) different MULTIPLIER Play Symbols.

2.3 Procedure for Claiming Prizes.

A. To claim a "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game prize of $3.00, $5.00, $10.00, $15.00, $20.00, $30.00, $45.00, $90.00, $150 or $300, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $30.00, $45.00, $90.00, $150 or $300 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game prize of $2,000 or $60,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 14 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$60,000 BLITZ WORD SEARCH" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any Non-Winning "$60,000 BLITZ WORD SEARCH" Scratch Ticket may be entered

into one (1) of five (5) promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Scratch Ticket for information on eligibility and entry requirements.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 20,040,000 Scratch Tickets in the Scratch Ticket Game No. 2618. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2618 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$3.00	2,084,160	9.62
$5.00	801,600	25.00
$10.00	761,520	26.32
$15.00	521,040	38.46
$20.00	280,560	71.43
$30.00	120,240	166.67
$45.00	21,710	923.08
$90.00	16,700	1,200.00
$150	4,008	5,000.00
$300	835	24,000.00
$2,000	40	501,000.00
$60,000	8	2,505,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.34. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2618 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2618, the State Lottery Act (Texas Government Code, Chap-

ter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405338
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2619 "$200,000 BLITZ"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2619 is "$200,000 BLITZ". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. Tickets for Scratch Ticket Game No. 2619 shall be $5.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2619.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: ARMORED CAR SYMBOL, ATM CARD SYMBOL, BANK SYMBOL, BILL SYMBOL, CHECK SYMBOL, CHIP SYMBOL, CROWN SYMBOL, DICE SYMBOL, STAR SYMBOL, REGISTER SYMBOL, RING SYMBOL, VAULT SYMBOL, 01, 02, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, MONEY BAG SYMBOL, 10X SYMBOL, 20X SYMBOL, 50X SYMBOL, $5.00, $10.00, $15.00, $25.00, $50.00, $100, $500, $5,000 and $200,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2619 - 1.2D

PLAY SYMBOL	CAPTION
ARMORED CAR SYMBOL	ARMCAR
ATM CARD SYMBOL	CARD
BANK SYMBOL	BANK
BILL SYMBOL	BILL
CHECK SYMBOL	CHECK
CHIP SYMBOL	CHIP
CROWN SYMBOL	CROWN
DICE SYMBOL	DICE
STAR SYMBOL	STAR
REGISTER SYMBOL	REGISTER
RING SYMBOL	RING
VAULT SYMBOL	VAULT
01	ONE
02	TWO
03	THR
04	FOR
05	FIV
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN

17	SVT
18	ETN
19	NTN
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
46	FRSX

47	FRSV
48	FRET
49	FRNI
51	FFON
52	FFTO
53	FFTH
54	FFFR
55	FFFV
56	FFSX
57	FFSV
58	FFET
59	FFNI
MONEY BAG SYMBOL	WIN$
10X SYMBOL	WINX10
20X SYMBOL	WINX20
50X SYMBOL	WINX50
$5.00	FIV$
$10.00	TEN$
$15.00	FFN$
$25.00	TWFV$
$50.00	FFTY$
$100	ONHN
$500	FVHN
$5,000	FVTH
$200,000	200TH

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2619), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start

with 001 and end with 075 within each Pack. The format will be: 2619-0000001-001.

H. Pack - A Pack of "$200,000 BLITZ" Scratch Ticket Game contains 075 Scratch Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The Packs will alternate. One will show the front of Ticket 001 and back of 075 while the other fold will show the back of Ticket 001 and front of 075.

I. Non-Winning Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - A Texas Lottery "$200,000 BLITZ" Scratch Ticket Game No. 2619.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$200,000 BLITZ" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose fifty (50) Play Symbols. BONUS $25 SPOT: If a player reveals 2 matching Play Symbols in the BONUS $25 SPOT, the player wins $25. BONUS $50 SPOT: If a player reveals 2 matching Play Symbols in the BONUS $50 SPOT, the player wins $50. BONUS $100 SPOT: If a player reveals 2 matching Play Symbols in the BONUS $100 SPOT, the player wins $100. $200,000 BLITZ PLAY INSTRUCTIONS: If the player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "MONEY BAG" Play Symbol, the player wins the prize for that symbol instantly. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the player reveals a "20X" Play Symbol, the player wins 20 TIMES the prize for that symbol. If the player reveals a "50X" Play Symbol, the player wins 50 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly fifty (50) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly fifty (50) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the fifty (50) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the fifty (50) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: A Ticket can win up to twenty-three (23) times in accordance with the prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

D. KEY NUMBER MATCH: Each Ticket will have four (4) different WINNING NUMBERS Play Symbols.

E. KEY NUMBER MATCH: Non-winning YOUR NUMBERS Play Symbols will all be different.

F. KEY NUMBER MATCH: Non-winning Prize Symbols will never appear more than three (3) times on a Ticket.

G. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20) and "50X" (WINX50) Play Symbols will never appear in the WINNING NUMBERS Play Symbol spots.

H. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20) and "50X" (WINX50) Play Symbols will never appear in any of the BONUS SPOT play areas.

I. KEY NUMBER MATCH: The "10X" (WINX10), "20X" (WINX20) and "50X" (WINX50) Play Symbols will only appear on winning Tickets as dictated by the prize structure.

J. KEY NUMBER MATCH: Non-winning Prize Symbols will never be the same as winning Prize Symbol(s).

K. KEY NUMBER MATCH: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 15 and $15).

L. BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT: Matching Play Symbols will only appear as dictated by the prize structure in winning BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT play areas.

M. BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT: A Play Symbol will not be used more than one (1) time per Ticket across the BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT play areas, unless used in a winning combination.

N. BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT: The BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT Play Symbols will never appear in the WINNING NUMBERS or YOUR NUMBERS Play Symbol spots.

O. BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT: In the BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT play areas, non-winning Play Symbols will not be the same as winning Play Symbols.

P. BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT: The BONUS $25 SPOT, BONUS $50 SPOT and BONUS $100 SPOT play areas will each be played separately.

2.3 Procedure for Claiming Prizes.

A. To claim a "$200,000 BLITZ" Scratch Ticket Game prize of $5.00, $10.00, $15.00, $25.00, $50.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $25.00, $50.00, $100 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$200,000 BLITZ" Scratch Ticket Game prize of $5,000 or $200,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$200,000 BLITZ" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 14 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$200,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$200,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any Non-Winning "$200,000 BLITZ" Scratch Ticket may be entered into one (1) of five (5) promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Scratch Ticket for information on eligibility and entry requirements.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 17,040,000 Scratch Tickets in the Scratch Ticket Game No. 2619. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2619 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$5.00	1,817,600	9.38
$10.00	1,136,000	15.00
$15.00	454,400	37.50
$25.00	511,200	33.33
$50.00	227,200	75.00
$100	32,092	530.97
$500	994	17,142.86
$5,000	13	1,310,769.23
$200,000	5	3,408,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.08. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2619 without advance notice, at which point no further

Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2619, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405340
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2620 "$500,000 BLITZ"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2620 is "$500,000 BLITZ". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. Tickets for Scratch Ticket Game No. 2620 shall be $10.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2620.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: ARMORED CAR SYMBOL, BANK SYMBOL, BAR SYMBOL, BELL SYMBOL, BILL SYMBOL, ATM CARD SYMBOL, CHECK SYMBOL, CHERRY SYMBOL, CHIP SYMBOL, CLUB SYMBOL, CROWN SYMBOL, DIAMOND SYMBOL, DICE SYMBOL, HEART SYMBOL, STAR SYMBOL, NECKLACE SYMBOL, REGISTER SYMBOL, RING SYMBOL, SEVEN SYMBOL, SPADE SYMBOL, SUN SYMBOL, VAULT SYMBOL, 01, 02, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, MONEY BAG SYMBOL, 10X SYMBOL, 20X SYMBOL, 50X SYMBOL, 100X SYMBOL, $10.00, $20.00, $30.00, $50.00, $100, $200, $500, $1,000, $10,000 and $500,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2620 - 1.2D

PLAY SYMBOL	CAPTION
ARMORED CAR SYMBOL	ARMCAR
BANK SYMBOL	BANK
BAR SYMBOL	BAR
BELL SYMBOL	BELL
BILL SYMBOL	BILL
ATM CARD SYMBOL	CARD
CHECK SYMBOL	CHECK
CHERRY SYMBOL	CHERRY
CHIP SYMBOL	CHIP
CLUB SYMBOL	CLUB
CROWN SYMBOL	CROWN
DIAMOND SYMBOL	DIAMOND
DICE SYMBOL	DICE
HEART SYMBOL	HEART
STAR SYMBOL	STAR
NECKLACE SYMBOL	NECKLACE
REGISTER SYMBOL	REGISTER
RING SYMBOL	RING
SEVEN SYMBOL	SEVEN
SPADE SYMBOL	SPADE
SUN SYMBOL	SUN
VAULT SYMBOL	VAULT
01	ONE
02	TWO
03	THR
04	FOR
05	FIV

06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX

37	TRSV
38	TRET
39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
46	FRSX
47	FRSV
48	FRET
49	FRNI
51	FFON
52	FFTO
53	FFTH
54	FFFR
55	FFFV
56	FFSX
57	FFSV
58	FFET
59	FFNI
60	SXTY
61	SXON
62	SXTO
63	SXTH
64	SXFR
65	SXFV
66	SXSX

67	SXSV
68	SXET
69	SXNI
MONEY BAG SYMBOL	WIN$
10X SYMBOL	WINX10
20X SYMBOL	WINX20
50X SYMBOL	WINX50
100X SYMBOL	WINX100
$10.00	TEN$
$20.00	TWY$
$30.00	TRTY$
$50.00	FFTY$
$100	ONHN
$200	TOHN
$500	FVHN
$1,000	ONTH
$10,000	10TH
$500,000	500TH

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2620), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 050 within each Pack. The format will be: 2620-0000001-001.

H. Pack - A Pack of "$500,000 BLITZ" Scratch Ticket Game contains 050 Scratch Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket back 001 and 050 will both be exposed.

I. Non-Winning Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - A Texas Lottery "$500,000 BLITZ" Scratch Ticket Game No. 2620.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$500,000 BLITZ" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose sixty-five (65) Play Symbols. BONUS $50 SPOT: If a player reveals 2 matching Play Symbols in the same BONUS $50 SPOT, the player wins $50. BONUS $100 SPOT: If a player reveals 2 matching Play Symbols in the same BONUS $100 SPOT, the player wins $100. $500,000 BLITZ Play Instructions: If the player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "MONEY BAG" Play Symbol, the player wins the prize for that symbol instantly. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the

player reveals a "20X" Play Symbol, the player wins 20 TIMES the prize for that symbol. If the player reveals a "50X" Play Symbol, the player wins 50 TIMES the prize for that symbol. If the player reveals a "100X" Play Symbol, the player wins 100 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly sixty-five (65) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly sixty-five (65) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the sixty-five (65) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the sixty-five (65) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: A Ticket can win up to thirty (30) times in accordance with the prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

D. KEY NUMBER MATCH: Each Ticket will have five (5) different WINNING NUMBERS Play Symbols.

E. KEY NUMBER MATCH: Non-winning YOUR NUMBERS Play Symbols will all be different.

F. KEY NUMBER MATCH: Non-winning Prize Symbols will never appear more than four (4) times on a Ticket.

G. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20), "50X" (WINX50) and "100X" (WINX100) Play Symbols will never appear in the WINNING NUMBERS Play Symbol spots.

H. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20), "50X" (WINX50) and "100X" (WINX100) Play Symbols will never appear in any of the BONUS SPOT play areas.

I. KEY NUMBER MATCH: The "10X" (WINX10), "20X" (WINX20), "50X" (WINX50) and "100X" (WINX100) Play Symbols will only appear on winning Tickets as dictated by the prize structure.

J. KEY NUMBER MATCH: Non-winning Prize Symbols will never be the same as winning Prize Symbol(s).

K. KEY NUMBER MATCH: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 20 and $20).

L. BONUS $50 SPOTS and BONUS $100 SPOTS: Matching Play Symbols will only appear as dictated by the prize structure in winning BONUS $50 SPOT and BONUS $100 SPOT play areas.

M. BONUS $50 SPOTS and BONUS $100 SPOTS: A Play Symbol will not be used more than one (1) time per Ticket across the BONUS $50 SPOT and BONUS $100 SPOT play areas, unless used in a winning combination.

N. BONUS $50 SPOTS and BONUS $100 SPOTS: The BONUS $50 SPOT and BONUS $100 SPOT Play Symbols will never appear in the WINNING NUMBERS or YOUR NUMBERS Play Symbol spots.

O. BONUS $50 SPOTS and BONUS $100 SPOTS: In the BONUS $50 SPOT and BONUS $100 SPOT play areas, non-winning Play Symbols will not be the same as winning Play Symbols.

P. BONUS $50 SPOTS and BONUS $100 SPOTS: The BONUS $50 SPOT and BONUS $100 SPOT play areas will each be played separately.

2.3 Procedure for Claiming Prizes.

A. To claim a "$500,000 BLITZ" Scratch Ticket Game prize of $10.00, $20.00, $30.00, $50.00, $100, $200 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $30.00, $50.00, $100, $200 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$500,000 BLITZ" Scratch Ticket Game prize of $1,000, $10,000 or $500,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$500,000 BLITZ" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 14 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$500,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$500,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any Non-Winning "$500,000 BLITZ" Scratch Ticket may be entered into one (1) of five (5) promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Scratch Ticket for information on eligibility and entry requirements.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the

Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 13,200,000 Scratch Tickets in the Scratch Ticket Game No. 2620. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2620 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$10.00	1,452,000	9.09
$20.00	924,000	14.29
$30.00	462,000	28.57
$50.00	462,000	28.57
$100	132,000	100.00
$200	17,050	774.19
$500	1,100	12,000.00
$1,000	208	63,461.54
$10,000	11	1,200,000.00
$500,000	4	3,300,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.83. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2620 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2620, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405341
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2621 "$1,000,000 BLITZ"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2621 is "$1,000,000 BLITZ". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. Tickets for Scratch Ticket Game No. 2621 shall be $20.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2621.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: ARMORED CAR SYMBOL, ATM CARD SYMBOL, BANK SYMBOL, BAR SYMBOL, BELL SYMBOL, CHECK SYMBOL, CHERRY SYMBOL, CHIP SYMBOL, CLUB SYMBOL, CROWN SYMBOL, DIAMOND SYMBOL, HEART SYMBOL, NECKLACE SYMBOL, REGISTER SYMBOL, RING SYMBOL, SEVEN SYMBOL, SPADE SYMBOL, STAR SYMBOL, SUN SYMBOL, VAULT SYMBOL, 01, 02, 03, 04, 05, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 10X SYMBOL, 20X SYMBOL, 50X SYMBOL, 100X SYMBOL, 200X SYMBOL, MONEY BAG SYMBOL, $20.00, $40.00, $50.00, $100, $200, $500, $2,000, $20,000 and $1,000,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2621 - 1.2D

PLAY SYMBOL	CAPTION
ARMORED CAR SYMBOL	ARMCAR
ATM CARD SYMBOL	CARD
BANK SYMBOL	BANK
BAR SYMBOL	BAR
BELL SYMBOL	BELL
CHECK SYMBOL	CHECK
CHERRY SYMBOL	CHERRY
CHIP SYMBOL	CHIP
CLUB SYMBOL	CLUB
CROWN SYMBOL	CROWN
DIAMOND SYMBOL	DIAMOND
HEART SYMBOL	HEART
NECKLACE SYMBOL	NECKLACE
REGISTER SYMBOL	REGISTER
RING SYMBOL	RING
SEVEN SYMBOL	SEVEN
SPADE SYMBOL	SPADE
STAR SYMBOL	STAR
SUN SYMBOL	SUN
VAULT SYMBOL	VAULT
01	ONE
02	TWO
03	THR
04	FOR
05	FIV
06	SIX
07	SVN

08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET

39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
46	FRSX
47	FRSV
48	FRET
49	FRNI
51	FFON
52	FFTO
53	FFTH
54	FFFR
55	FFFV
56	FFSX
57	FFSV
58	FFET
59	FFNI
60	SXTY
61	SXON
62	SXTO
63	SXTH
64	SXFR
65	SXFV
66	SXSX
67	SXSV
68	SXET

69	SXNI
70	SVTY
71	SVON
72	SVTO
73	SVTH
74	SVFR
75	SVFV
76	SVSX
77	SVSV
78	SVET
79	SVNI
10X SYMBOL	WINX10
20X SYMBOL	WINX20
50X SYMBOL	WINX50
100X SYMBOL	WINX100
200X SYMBOL	WINX200
MONEY BAG SYMBOL	WIN$
$20.00	TWY$
$40.00	FRTY$
$50.00	FFTY$
$100	ONHN
$200	TOHN
$500	FVHN
$2,000	TOTH
$20,000	20TH
$1,000,000	TPPZ

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2621), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 025 within each Pack. The format will be: 2621-0000001-001.

H. Pack - A Pack of "$1,000,000 BLITZ" Scratch Ticket Game contains 025 Scratch Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The Packs will alternate. One will show the front of Ticket 001 and back of 025 while the other fold will show the back of Ticket 001 and front of 025.

I. Non-Winning Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - A Texas Lottery "$1,000,000 BLITZ" Scratch Ticket Game No. 2621.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$1,000,000 BLITZ" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose seventy-six (76) Play Symbols. BONUS $50 SPOT: If a player reveals 2 matching Play Symbols in the same BONUS $50 SPOT, the player wins $50. BONUS $100 SPOT: If a player reveals 2 matching Play Symbols in the same BONUS $100 SPOT, the player wins $100. BONUS $200 SPOT: If a player reveals 2 matching Play Symbols in the same BONUS $200 SPOT, the player wins $200. $1,000,000 BLITZ Play Instructions: If the player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "MONEY BAG" Play Symbol, the player wins the prize for that symbol instantly. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the player reveals a "20X" Play Symbol, the player wins 20 TIMES the prize for that symbol. If the player reveals a "50X" Play Symbol, the player wins 50 TIMES the prize for that symbol. If the player reveals a "100X" Play Symbol, the player wins 100 TIMES the prize for that symbol. If the player reveals a "200X" Play Symbol, the player wins 200 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly seventy-six (76) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly seventy-six (76) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the seventy-six (76) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the seventy-six (76) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: A Ticket can win up to thirty-five (35) times in accordance with the prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

D. KEY NUMBER MATCH: Each Ticket will have six (6) different WINNING NUMBERS Play Symbols.

E. KEY NUMBER MATCH: Non-winning YOUR NUMBERS Play Symbols will all be different.

F. KEY NUMBER MATCH: Non-winning Prize Symbols will never appear more than four (4) times on a Ticket.

G. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20), "50X" (WINX50), "100X" (WINX100) and "200X" (WINX200) Play Symbols will never appear in the WINNING NUMBERS Play Symbol spots.

H. KEY NUMBER MATCH: The "MONEY BAG" (WIN$), "10X" (WINX10), "20X" (WINX20), "50X" (WINX50), "100X" (WINX100) and "200X" (WINX200) Play Symbols will never appear in any of the BONUS SPOT play areas.

I. KEY NUMBER MATCH: The "10X" (WINX10), "20X" (WINX20), "50X" (WINX50), "100X" (WINX100) and "200X" (WINX200) Play Symbols will only appear on winning Tickets as dictated by the prize structure.

J. KEY NUMBER MATCH: Non-winning Prize Symbols will never be the same as the winning Prize Symbol(s).

K. KEY NUMBER MATCH: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 40 and $40).

L. BONUS $50 SPOTS, BONUS $100 SPOT and BONUS $200 SPOTS: Matching Play Symbols will only appear as dictated by the prize structure in winning BONUS $50 SPOT, BONUS $100 SPOT and BONUS $200 SPOT play areas.

M. BONUS $50 SPOTS, BONUS $100 SPOT and BONUS $200 SPOTS: A Play Symbol will not be used more than one (1) time per Ticket across the BONUS $50 SPOT, BONUS $100 SPOT and BONUS $200 SPOT play areas, unless used in a winning combination.

N. BONUS $50 SPOTS, BONUS $100 SPOT and BONUS $200 SPOTS: The BONUS $50 SPOT, BONUS $100 SPOT and BONUS $200 SPOT Play Symbols will never appear in the WINNING NUMBERS or YOUR NUMBERS Play Symbols spots.

O. BONUS $50 SPOTS, BONUS $100 SPOT and BONUS $200 SPOTS: In the BONUS $50 SPOT, BONUS $100 SPOT and BONUS $200 SPOT play areas, non-winning Play Symbols will not be the same as winning Play Symbols.

P. BONUS $50 SPOTS, BONUS $100 SPOT and BONUS $200 SPOTS: The BONUS $50 SPOT, BONUS $100 SPOT and BONUS $200 SPOT play areas will each be played separately.

2.3 Procedure for Claiming Prizes.

A. To claim a "$1,000,000 BLITZ" Scratch Ticket Game prize of $20.00, $40.00, $50.00, $100, $200 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $40.00, $50.00, $100, $200 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$1,000,000 BLITZ" Scratch Ticket Game prize of $2,000, $20,000 or $1,000,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$1,000,000 BLITZ" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

F. If a person is indebted or owes delinquent taxes to the State, and is selected as a winner in a promotional second-chance drawing, the debt to the State must be paid within 14 days of notification or the prize will be awarded to an Alternate.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$1,000,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$1,000,000 BLITZ" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

2.9 Promotional Second-Chance Drawings. Any Non-Winning "$1,000,000 BLITZ" Scratch Ticket may be entered into one (1) of five (5) promotional drawings for a chance to win a promotional second-chance drawing prize. See instructions on the back of the Scratch Ticket for information on eligibility and entry requirements.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 7,200,000 Scratch Tickets in the Scratch Ticket Game No. 2621. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2621 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$20.00	720,000	10.00
$40.00	432,000	16.67
$50.00	360,000	20.00
$100	360,000	20.00
$200	45,840	157.07
$500	7,500	960.00
$2,000	180	40,000.00
$20,000	33	218,181.82
$1,000,000	4	1,800,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.74. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2621 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2621, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405342
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Scratch Ticket Game Number 2626 "$50 BLOWOUT"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2629 is "$50 BLOWOUT". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2629 shall be $5.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2629.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 01, 02, 03, 04, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, MONEY BAG SYMBOL, $5.00, $10.00, $20.00 and $50.00.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2629 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
02	TWO
03	THR
04	FOR
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY

31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
MONEY BAG SYMBOL	WIN$50
$5.00	FIV$
$10.00	TEN$
$20.00	TWY$
$50.00	FFTY$

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2629), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 075 within each Pack. The format will be: 2629-0000001-001.

H. Pack - A Pack of the "$50 BLOWOUT" Scratch Ticket Game contains 075 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The Packs will alternate. One will show the front of Ticket 001 and back of 075 while the other fold will show the back of Ticket 001 and front of 075.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - Texas Lottery "$50 BLOWOUT" Scratch Ticket Game No. 2629.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$50 BLOWOUT" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose forty-five (45) Play Symbols. If a player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "MONEY BAG" Play Symbol, the player wins $50 instantly! No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly forty-five (45) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly forty-five (45) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the forty-five (45) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the forty-five (45) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. KEY NUMBER MATCH: There will be no matching non-winning YOUR NUMBERS Play Symbols on a Ticket.

D. KEY NUMBER MATCH: There will be no matching WINNING NUMBERS Play Symbols on a Ticket.

E. KEY NUMBER MATCH: A Ticket may have up to five (5) matching non-winning Prize Symbols, unless restricted by other parameters, play action or prize structure.

F. KEY NUMBER MATCH: The "MONEY BAG" (WIN$50) Play Symbol may only appear one (1) time on winning Tickets.

G. KEY NUMBER MATCH: The "MONEY BAG" (WIN$50) Play Symbol will only appear on winning Tickets and will only appear with the $50 Prize Symbol.

2.3 Procedure for Claiming Prizes.

A. To claim a "$50 BLOWOUT" Scratch Ticket Game prize of $5.00, $10.00, $20.00 or $50.00, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. As an alternative method of claiming a "$50 BLOWOUT" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

D. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$50 BLOWOUT" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$50 BLOWOUT" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Prizes. There will be approximately 5,520,000 Scratch Tickets in Scratch Ticket Game No. 2629. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2629 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$5.00	368,000	15.00
$10.00	607,200	9.09
$20.00	312,800	17.65
$50.00	92,000	60.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.00. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2629 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the

Scratch Ticket closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2629, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202405336
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 6, 2024

Texas Parks and Wildlife Department

Notice of a Public Comment Hearing on an Application for a Sand and Gravel Permit

Notice of a Public Comment Hearing on an Application for a Sand and Gravel Permit

The City of Belton has applied to the Texas Parks and Wildlife Department (TPWD) for an Individual Permit pursuant to Texas Parks and Wildlife Code, Chapter 86, to remove or disturb 1,000 cubic yards of sedimentary material within Nolan Creek in Bell County. The purpose is to maintain stream flow and access to recreation features in the creek. Area 1 is located at GPS coordinates 31.054212, -97.463028, approximately 160 feet west of S. Penelope Street. Sedimentary material removal is planned from Area 1. Area 2 is located at GPS coordinates 31.054548, -97.463857 under State Highway 317 Bridge at Nolan Creek. Sedimentary material is planned to be relocated from Area 2 to the shoreline to reshape the bank to prevent excess sediment from blocking the flow of the stream. This notice is being published and mailed pursuant to 31 TAC §69.105(d).

TPWD will hold a public comment hearing regarding the application at 11:00 a.m. on December 13, 2024, at TPWD headquarters, located at 4200 Smith School Road, Austin, Texas 78744. A remote participation option will be available upon request. Potential attendees should contact Sue Reilly at (512) 389-8622 or at sue.reilly@tpwd.texas.gov for information on how to participate in the hearing remotely. The hearing is not a contested case hearing under the Texas Administrative Procedure Act. Oral and written public comment will be accepted during the hearing.

Written comments may be submitted directly to TPWD and must be received no later than 30 days after the date of publication of this notice in the *Texas Register.* A written request for a contested case hearing from an applicant or a person with a justiciable interest may also be submitted and must be received by TPWD prior to the close of the public comment period. Timely hearing requests shall be referred to the State Office of Administrative Hearings. Submit written comments, questions, requests to review the application, or requests for a contested case hearing to: TPWD Sand and Gravel Program by mail: Attn: Sue Reilly, Texas Parks and Wildlife Department, Inland Fisheries Division, 4200 Smith School Road, Austin, Texas 78744; or via e-mail: sand.gravel@tpwd.texas.gov.

TRD-202405343
James Murphy
General Counsel
Texas Parks and Wildlife Department
Filed: November 6, 2024

Supreme Court of Texas

Order Delaying Effective Date of Proposed Rules Governing Licensed Legal Paraprofessionals and Licensed Court-Access Assistants

Supreme Court of Texas

Misc. Docket No. 24-9095

Order Delaying Effective Date of Proposed Rules Governing Licensed Legal Paraprofessionals and Licensed Court-Access Assistants

ORDERED that:

1. On August 6, 2024, in Misc. Dkt. No. 24-9050, the Court gave preliminary approval to rules governing licensed legal paraprofessionals and court-access assistants. Misc. Dkt. No. 24-9050 invites public comments until November 1, 2024, and provides for an expected effective date of December 1, 2024.

2. In order to give due consideration to the comments received, the Court hereby delays the expected effective date of the rules proposed in Misc. Dkt. No. 24-9050 pending further order of the Court.

3. The Clerk is directed to:

   a. file a copy of this Order with the Secretary of State;

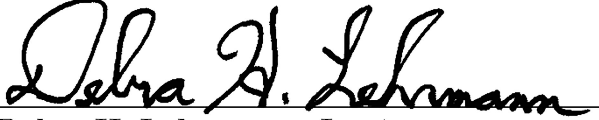
   b. cause a copy of this Order to be mailed to each registered member of the State Bar of Texas by publication in the *Texas Bar Journal*;

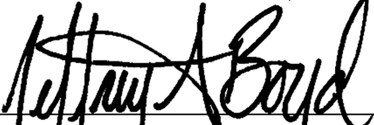
   c. send a copy of this Order to each elected member of the Legislature; and

   d. submit a copy of this Order for publication in the *Texas Register*.

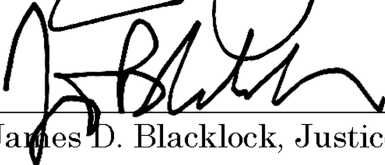
Dated: November 4, 2024.

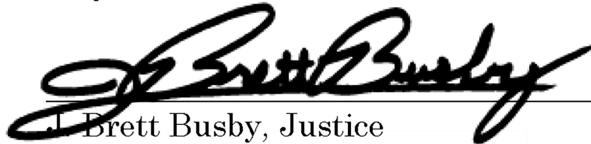
Nathan L. Hecht, Chief Justice


Debra H. Lehrmann, Justice


Jeffrey S. Boyd, Justice

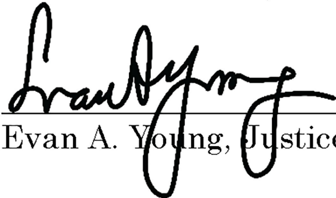
John P. Devine, Justice


James D. Blacklock, Justice


J. Brett Busby, Justice

Jane N. Bland, Justice

Rebeca A. Huddle, Justice


Evan A. Young, Justice

TRD-202405320
Jaclyn Daumerie
Rules Attorney
Supreme Court of Texas
Filed: November 5, 2024

Texas Department of Transportation

Notice of Agreement on Identification of Future Transportation Corridors Within Harris County

The Texas Department of Transportation and Harris County, Texas, have entered into an agreement that identifies future transportation corridors within Harris County in accordance with Transportation Code, Section 201.619. Copies of the agreement and all plans referred to by

the agreement are available at the department's Houston District Office, 7600 Washington Avenue, Houston, Texas 77007.

TRD-202405325
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Filed: November 5, 2024

Request for Proposals - Traffic Safety Program

In accordance with 43 TAC §25.901 et seq., the Texas Department of Transportation (TxDOT) is requesting project proposals to support the targets and strategies of its traffic safety program to reduce the number of motor vehicle related crashes, injuries, and fatalities in Texas. These targets and strategies form the basis for the Federal Fiscal Year 2026 (FY 2026) Texas Highway Safety Plan (HSP).

Authority and responsibility for funding of the traffic safety grant program derives from the National Highway Safety Act of 1966 (23 USC §401 et seq.), and the Texas Traffic Safety Act of 1967 (Transportation Code, Chapter 723). The Behavioral Traffic Safety Section (TRF-BTS) is an integral part of TxDOT and works through 25 districts for local projects. The program is administered at the state level by TxDOT's Traffic Safety Division (TRF). The Executive Director of TxDOT is the designated Governor's Highway Safety Representative.

The following information is related to the FY 2026 Selective Traffic Enforcement Program (STEP) Traffic Safety Grants - Request for Proposals (RFP). Please review the full FY 2026 STEP RFP located online at: *https://egrants.bts.txdot.gov/eGrantsHelp/RFP/2026/RFP2026.pdf*

STEP Proposals for highway safety funding are due to the TRF-BTS no later than 5:00 p.m. CST, January 9, 2025.

Any additional questions or requests for information should be directed to the Police Traffic Services Program Manager, Larry Krantz, at larry.krantz@txdot.gov.

The proposals must be completed and submitted using eGrants, which can be found by going to *https://egrants.bts.txdot.gov/*

TRD-202405319
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Filed: November 5, 2024

How to Use the Texas Register

Information Available: The sections of the *Texas Register* represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules - sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Review of Agency Rules - notices of state agency rules review.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules - notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the *Texas Register* is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 24 of Volume 49 (2024) is cited as follows: 49 TexReg 24.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "49 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 49 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the *Texas Register* office, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using *Texas Register* indexes, the *Texas Administrative Code* section numbers, or TRD number.

Both the *Texas Register* and the *Texas Administrative Code* are available online at: http://www.sos.state.tx.us. The *Texas Register* is available in an .html version as well as a .pdf version through the internet. For website information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The *Texas Administrative Code (TAC)* is the compilation of all final state agency rules published in the *Texas Register*. Following its effective date, a rule is entered into the *Texas Administrative Code*. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the *TAC*.

The *TAC* volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete *TAC* is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The Titles of the *TAC*, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
26. Health and Human Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the *Texas Administrative Code*; *TAC* stands for the *Texas Administrative Code*; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to Update: To find out if a rule has changed since the publication of the current supplement to the *Texas Administrative Code*, please look at the *Index of Rules*.

The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the *Texas Register*.

If a rule has changed during the time period covered by the table, the rule's *TAC* number will be printed with the *Texas Register* page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
1 TAC §91.1……..950 *(P)*

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