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.

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

TRD-202405178
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 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.

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Karen Ray
Chief Counsel
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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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Karen Ray
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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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Chief Counsel
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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~~].

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. 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~~].

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. 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.

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 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.

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 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.

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

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.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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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.

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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
Texas Health and Human Services Commission
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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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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.

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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.

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For further information, please call: (512) 221-9021

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.

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

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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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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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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Karen Ray
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Texas Health and Human Services Commission
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For further information, please call: (512) 221-9021

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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.

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
Earliest possible date of adoption: December 15, 2024
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.

TRD-202405208
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 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.

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 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.

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
Earliest possible date of adoption: December 15, 2024
For further information, please call: (512) 221-9021

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.

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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 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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Karen Ray
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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.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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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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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 long-standing 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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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.

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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 and any other forms and documentation required to ensure the card-minding system is compliant with the standards in this subchapter.

[(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.

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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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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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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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TRD-202405312
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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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.

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Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
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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.

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Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
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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.

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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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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 health-care 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.

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Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
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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
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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.

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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

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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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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