TEXAS REGISTER

Volume 44 Number 2 *January 11, 2019* *Pages 167 - 296*

Sergio Ledesma

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

Texas Register, **(ISSN 0362-4781, USPS 12-0090),** is published weekly (52 times per year) for $340.00 ($502.00 for first class mail delivery) by Matthew Bender & Co., Inc., 3 Lear Jet Lane Suite 104, P O Box 1710, Latham, NY 12110.

The *Texas Register* is published under the Government Code, Title 10, Chapter 2002. Periodicals Postage Paid at Easton, MD and at additional mailing offices.

POSTMASTER: Send address changes to the *Texas Register,* 4810 Williamsburg Road, Unit 2, Hurlock, MD 21643.

a section of the
Office of the Secretary of State
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Austin, TX 78711
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In This Issue

THE ATTORNEY GENERAL

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

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

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

Requests for Opinions

RQ-0261-KP

Requestor:

Ms. Shelly Atteberry

Cooke County Auditor

Cooke County Courthouse

101 South Dixon Street

Gainesville, Texas 76240

Re: Whether a private attorney or collection agency that contracts with a county to collect delinquent amounts owed to county courts may charge defendants a fee for the use of credit cards (RQ-0261-KP)

Briefs requested by January 24, 2019

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

TRD-201805550
Amanda Crawford
General Counsel
Office of the Attorney General
Filed: December 21, 2018

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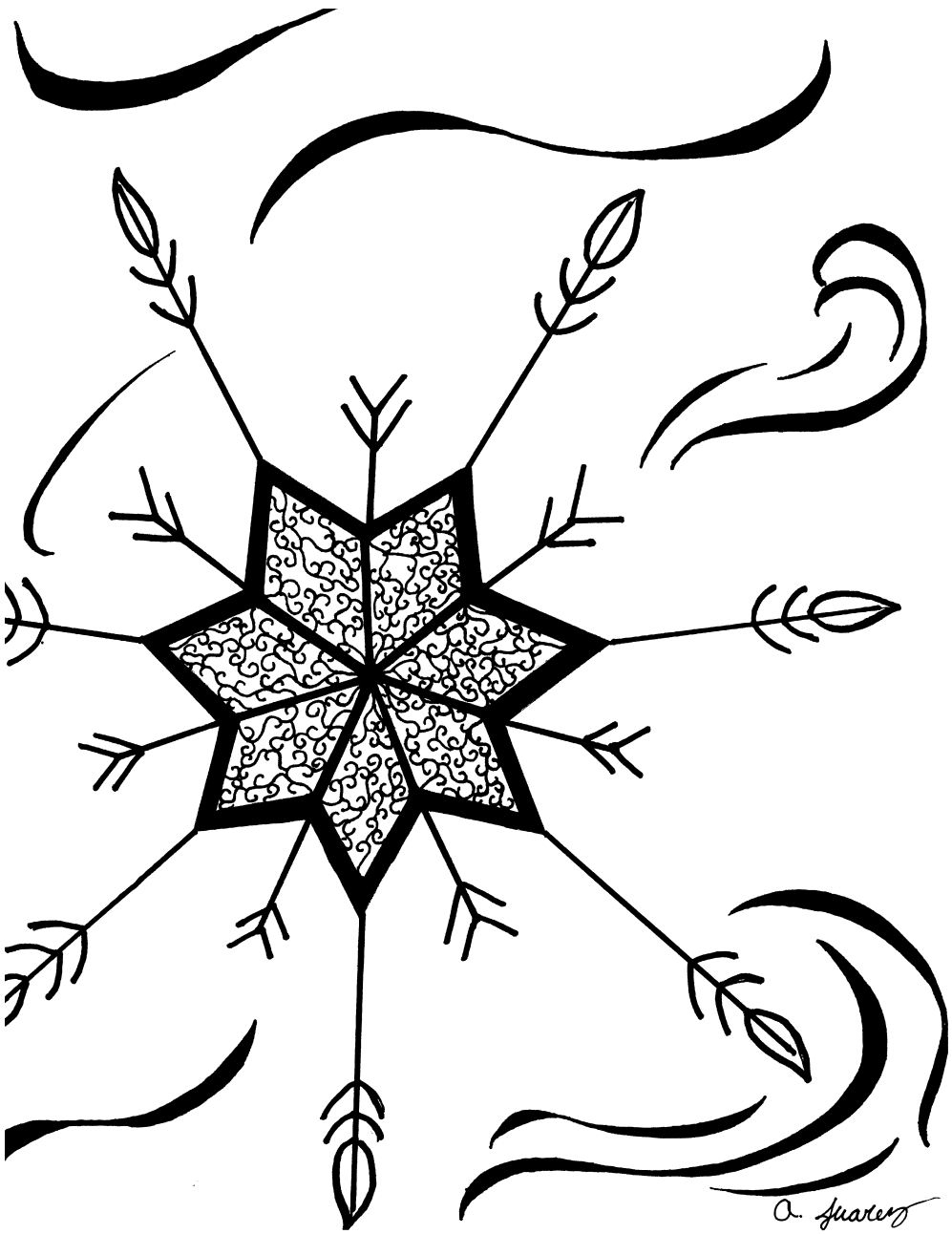

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, 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 354. MEDICAID HEALTH SERVICES

SUBCHAPTER C. CASE MANAGEMENT FOR CHILDREN WHO ARE BLIND AND VISUALLY IMPAIRED

1 TAC §§354.1501, 354.1503, 354.1505, 354.1507, 354.1509, 354.1511

The Texas Health and Human Services Commission (HHSC) proposes the repeal of Title 1, Part 15, Chapter 354, Subchapter C, Case Management for Children Who Are Blind and Visually Impaired, in its entirety, including §354.1501, concerning Definitions; §354.1503, concerning Eligible Individuals; §354.1505, concerning Case Management Services; §354.1507, concerning Service Limitations; §354.1509, concerning Provider Qualifications; and §354.1511, concerning Right to Appeal.

BACKGROUND AND PURPOSE

The repeal of the proposed rules aligns with Medicaid State Plan changes made effective February 15, 2017. The Centers for Medicare & Medicaid Services approved an administrative change for HHSC to continue to provide case management services for blind and visually impaired children and bill for service reimbursements through administrative claiming rather than the Medicaid fee-for-service reimbursement model. HHSC employees continue to provide uninterrupted case management services to eligible children who are blind or visually impaired.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the rules will be repealed, there will be no fiscal implications to state or local governments as a result of the repeals.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

(3) implementation of the repealed rules will not require an increase or decrease in future legislative appropriations;

(4) the repealed rules will not affect fees paid to the agency;

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

(6) the repealed rules will repeal existing rules;

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

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

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

Ms. Rymal has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules are being repealed as obsolete.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the rules as proposed.

There is no anticipated negative impact on local employment.

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.

PUBLIC BENEFIT

Stephanie Muth, State Medicaid Director, has determined that for each year of the first five years the repeal is effective, the public benefit anticipated as a result of the repeal is that program rules will align with the Medicaid State Plan.

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 Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 149030, Mail Code H600, Austin, Texas 78714-9030, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or e-mailed to *HHSRulesCoordinationOffice@hhsc.state.tx.us.*

To be considered, comments must be submitted no later than 30 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) e-mailed by midnight on the last day of the comment period. When e-mailing comments, please indicate "Comments on Proposed Rule 18R044 *Subchapter C repeal" in the subject line.

ADDITIONAL INFORMATION

For further information, please call: (512) 730-7415.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055(e), Executive Commissioner: General Responsibility for Health and Human Services System, which provides that the HHSC Executive Commissioner shall adopt rules for the operation and provision of health and human services by the health and human services system agencies.

The repeal implements Texas Government Code §531.021(a) and Texas Human Resources Code §32.021(a), which authorize HHSC to operate the Medicaid program.

§354.1501. Definitions.
§354.1503. Eligible Individuals.
§354.1505. Case Management Services.
§354.1507. Service Limitations.
§354.1509. Provider Qualifications.
§354.1511. Right to Appeal.

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 December 21, 2018.

TRD-201805561
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 730-7415

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CHAPTER 392. PURCHASE OF GOODS AND SERVICES FOR SPECIFIC HEALTH AND HUMAN SERVICES COMMISSION PROGRAMS SUBCHAPTER E. CONTRACT MANAGEMENT FOR DSHS FACILITIES AND CENTRAL OFFICE

1 TAC §392.411

The Texas Health and Human Services Commission (HHSC) proposes the repeal of §392.411, concerning Award of Construction Contracts.

Background and Purpose

Texas Health and Safety Code, §551.007 requires the HHSC Executive Commissioner to design, construct, equip, furnish, and maintain buildings and improvements authorized by law at facilities under HHSC's jurisdiction. Texas Government Code, §531.0055(e), (f)(4), and (j) also task the Executive Commissioner with the administrative duties of contracting and purchasing and adopting rules necessary to implement these duties. Section 392.411 requires HHSC to give notice of its intent to award construction contracts by publishing an invitation for bids (IFB) notice twice in two newspapers of general circulation. The repeal of §392.411 would allow posting of construction contracts on the Electronic State Business Daily and through the use of plan rooms. Government Code, Chapter 2269 governs the various procurement methods available for construction contracts. The current rule restricts the procurement method to only one type, and an IFB is not always the most appropriate procurement method for construction contracts. HHSC should determine the procurement method on a case-by-case basis pursuant to Chapter 2269 in order to best meet the business objective and project goals of each procurement. Therefore, HHSC has determined that the repeal of §392.411 is necessary to enable the procurement of construction contracts in the most fiscally efficient and statutorily compliant manner possible.

Section-by-Section Summary

The proposed repeal of §392.411 deletes the rule in its entirety.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that for each year of the first five years that the repealed section will be in effect, there may be fiscal implications to state government as a result of enforcing and administering the section as proposed. This rule is expected to provide an estimated $2,500 reduction in cost per construction project as contract bid invitations will no longer be placed in newspapers across the state. HHSC lacks sufficient data to provide an estimate of the total reduction in costs.

There will be no effect on local government.

Government Growth Impact Statement

In compliance with Government Code, §2001.0221, HHSC has determined that during the first five years the rule is repealed:

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

(2) implementation of the proposal will not affect the number of employee positions;

(3) implementation of the proposal will not require an increase or decrease in future legislative appropriations;

(4) the proposal will not affect fees paid to the agency;

(5) the proposal will not create a new rule;

(6) the proposal will repeal an existing rule;

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

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

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

Ms. Rymal has determined that there may be an adverse economic effect on small businesses, micro-businesses, or rural communities as the rule is proposed. HHSC will no longer be required to place invitations for construction contract bids in newspapers across the state. HHSC lacks sufficient data to determine which newspapers would be considered small or if micro-businesses or rural communities will be impacted.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the section as proposed.

There is no anticipated negative impact on local employment.

Costs to Regulated Persons

Government Code, §2001.0045 does not apply to this proposal because the proposed repeal does not impose a cost on regulated persons, including another state agency, a special district, or a local government.

Public Benefit

Kay Molina, Associate Commissioner of the Office of Compliance and Quality Control, has determined that for each year of the first five year period the proposed repeal is in effect the public benefit will be cost savings to HHSC, the ability to use more than one type of procurement method, and the ability to use a posting method already well accepted by the vendor community and freely available to the public.

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 Government Code, §2007.043.

Public Comment

Questions about the content of this proposal may be directed to Kay Molina at (512) 406-2451 in Procurement and Contracting Services.

Written comments on the proposal may be submitted to Kay Molina, Associate Commissioner of Compliance and Quality Control, Procurement and Contracting Services, Texas Health and Human Services Commission, 1100 W. 49th Street, Mail Code 2020, Austin, Texas 78756; or e-mailed to Kay.Molina@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register.*

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register.* The last day to submit comments falls on a Sunday; therefore, 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) e-mailed by midnight on the last day of the comment period. When e-mailing comments, please indicate "Comments on Proposed Rule 19R007" in the subject line.

ADDITIONAL INFORMATION

For further information, please call: (512) 406-2451.

Statutory Authority

The rule repeal is proposed under Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority.

The proposed rule repeal implements Government Code §531.0055(f)(4), which provides the Executive Commissioner with authority to contract for the Health and Human Services System, and Health and Safety Code §551.007, which requires the Executive Commissioner to build, furnish, and maintain buildings.

The proposed rule repeal is consistent with Government Code §531.00553 and Government Code Chapter 2269.

§392.411. Award of Construction Contracts.

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 December 21, 2018.

TRD-201805562
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 406-2451

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER S. WHOLESALE MARKETS

The Public Utility Commission of Texas (commission) proposes amendments to §25.505, relating to Resource Adequacy in the Electric Reliability Council of Texas power region and repeal of §25.508, relating to the High System-Wide Offer Cap in the Electric Reliability Council of Texas Power Region. The proposed amendments will provide for improved regulatory flexibility with respect to natural gas price indices to be used in the calculation of the peaker net margin, remove obsolete language, update reporting requirements consistent with current practices and the ERCOT Protocols, and clarify that ERCOT will not administer any administrative pricing mechanisms such as the Operating Reserve Demand Curve or the Reliability Deployment Price Adder in the event that the peaker net margin threshold is reached and the Low System-Wide Offer Cap is applied. The proposed repeal removes language that is now obsolete.

The commission also requests comment from interested persons on the following question: As an alternative to the changes in §25.505(f)(6)(A) of the proposed rule, should the commission instead consider eliminating the Low System-Wide Offer Cap from the scarcity pricing mechanism?

Growth Impact Statement

The agency provides the following governmental growth impact statement for the proposed rule, as required by Texas Government Code §2001.0221. The agency has determined that for each year of the first five years that the proposed rule is in effect, the following statements will apply:

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

(2) implementation of the proposed rule will not require the creation of new employee positions and will not require the elimination of existing employee positions;

(3) implementation of the proposed rule will not require an increase and will not require a decrease in future legislative appropriations to the agency;

(4) the proposed rule will not require an increase and will not require a decrease in fees paid to the agency;

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

(6) the proposed rule will repeal an existing regulation by deleting a rule that is obsolete;

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

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

Fiscal Impact on Small and Micro-Businesses and Rural Communities

There is no adverse economic effect anticipated for small businesses, micro-businesses, or rural communities as a result of implementing the proposed rule. Accordingly, no economic impact statement or regulatory flexibility analysis is required under Texas Government Code §2006.002(c).

Takings Impact Analysis

The commission has determined that the proposed rule will not be a taking of private property as defined in chapter 2007 of the Texas Government Code.

Fiscal Impact on State and Local Government

Kristin Abbott, Market Analyst, has determined that for the first five-year period the proposed amendments are in effect, there will be no fiscal implications for the state or for units of local government under Texas Government Code §2001.024(a)(4) as a result of enforcing or administering the sections.

Public Benefits

Kristin Abbott, Market Analyst, has also determined that for each year of the first five years the proposed section is in effect, the anticipated public benefits expected as a result of the adoption of the proposed rule will be improved clarity through updated language, improved clarity to the market, and improved alignment of regulations affecting the day-ahead and real-time markets. There will be no probable economic cost to persons required to comply with the rule under Texas Government Code §2001.024(a)(5).

Local Employment Impact Statement

For each year of the first five years the proposed section is in effect there should be no effect on a local economy; therefore, no local employment impact statement is required under Texas Government Code §2001.022.

Costs to Regulated Persons

Texas Government Code §2001.0045(b) does not apply to this rulemaking because the Public Utility Commission is expressly excluded under subsection §2001.0045(c)(7).

Public Hearing

The commission staff will conduct a public hearing on this rulemaking, if requested in accordance with Texas Government Code §2001.029, at the commission's offices located in the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701 on February 26, 2019. The request for a public hearing must be received within 30 days after publication.

Public Comments

Comments on the proposed amendment and repeal may be filed with the commission's filing clerk at 1701 North Congress Avenue, Austin, Texas or mailed to P.O. Box 13326, Austin, Texas 78711-3326, within 30 days after publication. Sixteen copies of comments to the proposed amendment and repeal are required to be filed by 16 TAC §22.71(c). Reply comments may be submitted within 45 days after publication. Comments should be organized in a manner consistent with the organization of the proposed rule. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the proposed rule. The commission will consider the costs and benefits in deciding whether to adopt the rule. All comments should refer to project number 48721.

16 TAC §25.505

The amendment is proposed under §14.002 of the Public Utility Regulatory Act, Tex. Util. Code Ann. (PURA), which provides the commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction and specifically, PURA §39.101, which establishes that customers are entitled to safe, reliable, and reasonably priced electricity, and gives the commission the authority to adopt and enforce rules to carry out these provisions; and §39.151, which grants the commission oversight and review authority over independent organizations such as ERCOT, directs the commission to adopt and enforce rules relating to the reliability of the regional electrical network and accounting for the production and delivery of electricity among generators and all other market participants, and authorizes the commission to delegate to an independent organization such as ERCOT responsibilities for establishing or enforcing such rules.

Cross reference to statutes: Public Utility Regulatory Act §§14.002, 39.101, and 39.151.

§25.505. Reporting Requirements and the Scarcity Pricing Mechanism [~~Resource Adequacy~~] in the Electric Reliability Council of Texas Power Region.

(a) General. The purpose of this section is to prescribe reporting requirements for the Electric Reliability Council of Texas (ERCOT) and market participants, and to establish a scarcity pricing mechanism for the ERCOT market [~~mechanisms that the Electric Reliability Council of Texas (ERCOT) shall establish to provide for resource adequacy in the energy-only market design that applies to the ERCOT power region. The mechanisms are intended to encourage market participants to build and maintain a mix of resources that sustain adequate supply of electric service in the ERCOT power region, and to encourage market participants to take advantage of practices such as hedging, long-term contracting between market participants that supply power and market participants that serve load, and price responsiveness by end-use customers~~].

(b) Definitions. The following terms, when used in this section, [~~shall~~] have the following meanings, unless the context indicates otherwise:

(1) Generation entity--an entity that owns or controls a generation resource.

[~~(2) Event trigger--a calculated value for each interval that is equal to 50 times the Houston Ship Channel natural gas price index for each operating day, expressed in dollars per megawatt-hour (MWh) or dollars per megawatt per hour (MW/h). The event trigger shall be applied solely for the purpose of establishing the timing of the publication of certain market data and shall not be construed to establish~~

the legitimacy of any offer, whether such offer is less than, equal to, or higher than the event trigger.]

(2) [(3)] Load entity--an entity that owns or controls a load resource[, including, but not limited to, a load acting as a resource (LaaR) or a balancing up load (BUL), as those terms are defined in the ERCOT Protocols].

(3) [(4)] Resource entity--an entity that is a generation entity or a load entity.

(c) Resource adequacy reports. ERCOT must publish a resource adequacy report by December 31 of each year that projects, for at least the next five years, the capability of existing and planned electric generation resources and load resources. ERCOT may publish other resource adequacy reports or forecasts as it deems appropriate. [Statement of opportunities (SOO). ERCOT shall publish a SOO that provides market participants with a projection of the capability of existing and planned electric generation resources, load resources, and transmission facilities to reliably meet ERCOT's projected needs. A SOO published in even-numbered years shall use a ten-year study horizon and be published by December 31 of those years. A SOO published in odd-numbered years shall use a five-year study horizon and be published on or around October 1 of those years.] ERCOT must [shall] prescribe [reporting] requirements for generation entities and transmission service providers (TSPs) to report [to ERCOT] their plans for adding new facilities, upgrading existing facilities, and mothballing or retiring existing facilities. ERCOT also must [shall] prescribe [reporting] requirements for load entities to report [to ERCOT] their plans for adding new load resources or retiring existing load resources.

(d) Daily assessment of system adequacy. Each day, ERCOT must publish a report that includes the following information for each hour for the seven days beginning with the day the report is published:

(1) System-wide load forecast; and

(2) Aggregated information on the availability of resources, by ERCOT load zone, including load resources. [Projected assessment of system adequacy (PASA). Beginning no later than October 1, 2006, unless otherwise specified below, ERCOT shall provide market participants with information to assess the adequacy of resources and transmission facilities to meet projected demand in the following two reports:]

[(1) Each month, ERCOT shall publish a Medium-Term PASA for each week of the subsequent three years beginning with the week after the Medium-Term PASA is published. At a minimum, each Medium-Term PASA shall include the following information:]

[(A) Load forecast by ERCOT zone or area;]

[(B) Ancillary service requirements;]

[(C) Transmission constraints; and]

[(D) Aggregated information on the availability of resources, by ERCOT zone or area, including load resources.]

[(2) Each day, ERCOT shall publish a Short-Term PASA for each hour for the seven days beginning with the day the Short-Term PASA is published.]

[(A) At a minimum, each Short-Term PASA shall include the following information:

(i) Load forecast by ERCOT zone or area;

(ii) Ancillary service requirements;

(iii) Transmission constraints; and

(iv) Aggregated information on the availability of resources, by ERCOT zone or area, including load resources.

(B) By October 1, 2006, ERCOT shall file at the commission a plan to incorporate the impact of transmission constraints into its Short-Term PASA at a later date.]

(e) Filing of resource and transmission information with ERCOT. ERCOT must [shall] prescribe reporting requirements for resource entities and TSPs for the preparation of the assessment required by subsection (d) of this section [PASAs]. At a minimum, the following information must [shall] be reported to ERCOT:

(1) TSPs will [shall] provide ERCOT with information on planned and existing transmission outages.

(2) Generation entities will [shall] provide ERCOT with information on planned and existing generation outages.

(3) Load entities will [shall] provide ERCOT with information on planned and existing availability of load resources [LaaRs], specified by type of ancillary service[, and BULs].

(4) Generation entities will [shall] provide ERCOT with a complete list of generation resource availability and performance capabilities, including, but not limited to:

(A) the net dependable capability of generation resources;

(B) projected output of non-dispatchable resources such as wind turbines, run-of-the-river hydro, and solar power; and

(C) output limitations on generation resources that result from fuel or environmental restrictions.

(5) Load serving entities (LSEs) will [shall] provide ERCOT with complete information on load response capabilities that are self-arranged or pursuant to bilateral agreements between LSEs and their customers.

[(f) Publication of resource and load information in ERCOT markets. To increase the transparency of the ERCOT-administered markets, ERCOT shall post at a publicly accessible location on its website, beginning no later than October 1, 2006, the information required pursuant to this subsection, unless a different date is specified by a paragraph of this subsection.]

[(1) The following information in aggregated form, for each settlement interval and for each area where available, shall be posted two calendar days after the day for which the information is accumulated.]

[(A) Quantities and prices of offers for energy and each type of ancillary capacity service, in the form of supply curves.]

[(B) Self-arranged energy and ancillary capacity services, for each type of service.]

[(C) Actual resource output.]

[(D) Load and resource output for all entities that dynamically schedule their resources.]

[(E) During the operation of the market under a zonal market design, scheduled load and actual load. During the operation of the market under a nodal market design, firm scheduled load, scheduled load with "up to" limits on congestion charges, and actual load.]

[(2) During the operation of the market under a nodal market design, the following day-ahead market information in aggregate form shall be posted two calendar days after the day for which the infor-

mation is accumulated: load bids, including virtual loads, in the form of day-ahead bid curves, and cleared load.]

[(3) The following information in entity-specific form, for each settlement interval, shall be posted as specified in subparagraphs (A)-(E) of this paragraph.]

[(A) During the operation of the market under a zonal market design:]

[(i) Portfolio offer curves for balancing energy and for each type of ancillary service, for each area where available, shall be posted 60 days after the day for which the information is accumulated beginning September 1, 2007, except that, for the highest-priced offer selected or dispatched by ERCOT for each interval after January 12, 2007, ERCOT shall post the offer price and the name of the entity submitting the offer 48 hours after the day for which the information is accumulated. In the event of interzonal congestion, ERCOT shall post, separately for each zone, the offer price and the name of the entity submitting the highest-priced offer selected or dispatched.]

[(ii) If the market clearing price for energy (MCPE) or the market clearing price for capacity (MCPC) exceeds the event trigger during any interval, the portion of every market participant's price-quantity offer pair for balancing energy service and each other ancillary service that is at or above the event trigger for that service and that interval shall be posted seven (7) days after the day for which the offer is submitted. ERCOT shall implement the requirements of this clause by September 1, 2007.]

[(iii) Other offer-specific information for each type of service and for each area where available shall be posted 90 days after the day for which the information is accumulated beginning March 1, 2007. Effective March 1, 2008, this information shall be posted 60 days after the day the information was accumulated. The information subject to this disclosure requirement is as follows:]

[(I) final energy schedules for each QSE;]

[(II) final ancillary services schedules for each QSE;]

[(III) resource plans for each QSE representing a resource;]

[(IV) actual output from each resource; and]

[(V) all dispatch instructions from ERCOT for balancing energy and ancillary services.]

[(iv) The information posted shall include the names of the resources in the portfolio that were committed, the name of the entity submitting the information, the name of the entity controlling each resource in the portfolio.]

[(B) Two months after the start of operation of the market under a nodal market design:]

[(i) Offer curves (prices and quantities) for each type of ancillary service and for energy at each settlement point in the real time market, shall be posted 60 days after the day for which the information is accumulated except that, for the highest-priced offer selected or dispatched for each interval on an ERCOT-wide basis, ERCOT shall post the offer price and the name of the entity submitting the offer 48 hours after the day for which the information is accumulated.]

[(ii) If the MCPE or the MCPC exceeds the event trigger during any interval, the portion of every market participant's price-quantity offer pairs for balancing energy service and each other ancillary service that is at or above the event trigger for that service and that interval shall be posted seven (7) days after the day for which the offer is submitted.]

[(iii) Other resource-specific information, as well as self-arranged energy and ancillary capacity services, and actual resource output, for each type of service and for each resource at each settlement point shall be posted 60 days after the day for which the information is accumulated.]

[(iv) The posted information shall be linked to the name of the resource (or identified as a virtual offer), the name of the entity submitting the information, and the name of the entity controlling the resource. If there are multiple offers for the resource, ERCOT shall post the specified information for each offer for the resource, including the name of the entity submitting the offer and the name of the entity controlling the resource.]

[(C) The load and generation resource output for each zone, for each entity that dynamically schedules its resources, shall be posted 90 days after the day for which the information is accumulated beginning March 1, 2007. Effective March 1, 2008, the information required by this subparagraph shall be posted 60 days after the day for which the information is accumulated.]

[(D) ERCOT shall use §25.502(d) of this title (relating to Pricing Safeguards in Markets Operated by the Electric Reliability Council of Texas) as a basis for determining the control of a resource and shall include this information in its market operations data system.]

[(E) After the start of operation of the market under a nodal market design, ERCOT shall begin posting transmission flows, voltages, transformer flows, voltages and tap positions (i.e., State Estimator data) 60 days after the day for which the data were accumulated or other time interval as established in clause (ii) of this subparagraph. The data released shall be made available simultaneously to all market participants.]

[(i) Notwithstanding the provisions of this subparagraph and the provisions of subparagraph (B) of this paragraph, ERCOT, in its sole discretion, shall release relevant State Estimator data earlier than 60 days after the day for which the information is accumulated if it determines the release is necessary to provide a complete and timely explanation and analysis of unexpected market operations and results or system events, including but not limited to pricing anomalies, recurring transmission congestion, and system disturbances. ERCOT's release of data under this clause shall be limited to intervals associated with the unexpected market or system event as determined by ERCOT. The data released shall be made available simultaneously to all market participants.]

[(ii) Notwithstanding the provisions of this subparagraph and the other provisions of subparagraph (B) of this paragraph, ERCOT shall, by the start of the nodal market, develop and post a redacted version of State Estimator data, as soon as reasonably practicable after collection of the data, so long as a redacted version excludes information (including but not limited to, voltages, transmission flows and transformer flows) from which resource-specific output levels or offer curves could continually and systematically be derived. Concurrently, in conjunction with the Independent Market Monitor and the commission Staff, ERCOT, through its stakeholder process, shall develop protocols that detail, at a minimum, the methodology, duration, and posting requirement of a redacted version of the State Estimator data. The redacted report methodology developed through the stakeholder process shall be completed within 90 days of the start of the nodal market. If ERCOT is unable to develop a cost effective protocol for the redaction process of the State Estimator data within 90 days of the start of the nodal market, then the following information shall be released as soon as reasonably practicable:]

[(I) ~~Current commercially significant constraints (CSCs) and closely related elements (CREs) line flows that are embodied in the competitive constraint list from the Competitive Constraint Test;]~~

[(II) ~~For phase shifting transformers, tap positions and line flows;]~~

[(III) ~~Voltages at all buses;]~~

[(IV) ~~Line flows on lines that make up interfaces (import, export, flow gate, or stability); and]~~

[(V) ~~Line flows on DC ties.~~

(iii) ~~In no event shall ERCOT disclose competitively sensitive consumption data.]~~

(f) [~~(g)~~] Scarcity pricing mechanism (SPM). ERCOT will [~~shall~~] administer the SPM. The SPM will [~~shall~~] operate as follows:

(1) The SPM will [~~shall~~] operate on an annual calendar year basis [~~resource adequacy cycle, starting on January 1 and ending on December 31 of each year~~].

(2) For each day[~~, of the annual resource adequacy cycle,~~] the peaking operating cost (POC) will [~~shall~~] be 10 times the natural gas price index value determined by ERCOT [~~daily Houston Ship Channel gas price index for the previous business day~~]. The POC is calculated in dollars per megawatt-hour (MWh).

(3) For the purpose of this section, the real-time energy price (RTEP) shall be measured as an average system-wide price as determined by ERCOT [~~the price at an ERCOT-calculated ERCOT-wide hub~~].

(4) In the annual resource adequacy cycle, the peaker net margin will [~~(PNM) shall~~] be calculated as:
Figure: 16 TAC §25.505(f)(4)

(5) Each day, ERCOT will [~~shall~~] post at a publicly accessible location on its website the updated value of the peaker net margin[~~PNM~~], in dollars per megawatt (MW).

(6) The system-wide offer caps will [~~shall~~] be as follows:

(A) The low system-wide offer cap (LCAP) will [~~shall~~] be set on a daily basis at the greater [~~higher~~] of:

(i) $2,000 per MWh and $2,000 per MW per hour; or

(ii) 50 times the natural gas price index value determined by ERCOT[~~daily Houston Ship Channel gas price index of the previous business day~~], expressed in dollars per MWh and dollars per MW per hour.

(B) The high system-wide offer cap (HCAP) will be $9,000 per MWh and $9,000 per MW per hour [~~shall be set:~~]

[(i) ~~Beginning on June 1, 2013 at $5,000 per MWh and $5,000 per MW per hour.]~~

[(ii) ~~Beginning on June 1, 2014 at $7,000 per MWh and $7,000 per MW per hour.]~~

[(iii) ~~Beginning on June 1, 2015 at $9,000 per MWh and $9,000 per MW per hour~~].

(C) The system-wide offer cap will be set equal to the HCAP at the beginning of each calendar year and maintained at this level as long as the peaker net margin during a calendar year does not exceed a threshold of three times the cost of new entry of new generation plants. [~~At the beginning of the annual resource adequacy cycle, the system-wide offer cap shall be set equal to the HCAP and, except for increases authorized in this section, maintained at this level as long as the PNM during an annual resource adequacy cycle is less than or equal to a threshold of $300,000 per MW in 2012 and 2013, or the threshold set by ERCOT for a subsequent year. For 2014 and each subsequent year, ERCOT shall set the PNM threshold at three times the cost of new entry of new generation plants. During an annual resource adequacy cycle, the system-wide offer cap shall be increased in accordance with the schedule authorized in this section unless the PNM threshold has been exceeded by that date.~~]

(D) If the peaker net margin exceeds the threshold established in subparagraph (C) of this paragraph during a calendar year, the system-wide offer cap will be set to the LCAP for the remainder of that calendar year. In this event, ERCOT will not apply any administrative pricing mechanism, such as the operating reserve demand curve or the reliability deployment price adder, for the remainder of that calendar year. Energy prices will not exceed the LCAP for the remainder of that calendar year [~~If the PNM threshold has been exceeded during an annual resource adequacy schedule, the system-wide offer cap shall be reset at the LCAP for the remainder of that annual resource adequacy cycle~~].

(E) [~~(D)~~] The Independent Market Monitor, as part of its responsibilities under [~~pursuant to~~] Public Utility Regulatory Act §39.1515(h), may conduct an annual review of the effectiveness of the SPM.

(g) [~~(h)~~] Development and implementation. ERCOT must [~~shall~~] use a stakeholder process to develop rules [~~protocols~~] that comply with this section. Nothing in this section prevents the commission from taking actions necessary to protect the public interest, including actions that are otherwise inconsistent with the other provisions in this section.

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

Filed with the Office of the Secretary of State on December 31, 2018.

TRD-201805589
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 936-7223

♦ ♦ ♦

16 TAC §25.508

The repeal is proposed under §14.002 of the Public Utility Regulatory Act, Tex. Util. Code Ann. (PURA), which provides the commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction and specifically, PURA §39.101, which establishes that customers are entitled to safe, reliable, and reasonably priced electricity, and gives the commission the authority to adopt and enforce rules to carry out these provisions; and §39.151, which grants the commission oversight and review authority over independent organizations such as ERCOT, directs the commission to adopt and enforce rules relating to the reliability of the regional electrical network and accounting for the production and delivery of electricity among generators and all other market participants, and authorizes the commission to delegate to an independent

organization such as ERCOT responsibilities for establishing or enforcing such rules.

Cross reference to statutes: Public Utility Regulatory Act §§14.002, 39.101, and 39.151.

§25.508. High System-Wide Offer Cap in the Electric Reliability Council of Texas Power Region.

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 December 31, 2018.

TRD-201805588
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 936-7223

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 289. RADIATION CONTROL
SUBCHAPTER E. REGISTRATION REGULATIONS

25 TAC §289.232

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (DSHS), proposes the repeal of §289.232 and new §289.232, concerning Radiation Control Regulations for Dental Radiation Machines.

BACKGROUND AND PURPOSE

The repeal and replacement with the new section are necessary due to extensive revisions made throughout the new section. The changes correct rule citation references, define registrant responsibilities, and mirror registration requirements in Title 25, Texas Administrative Code (TAC), §289.226, concerning the registration of radiation machine use and services. In addition, the new section is updated to reflect fee requirements in Title 25, TAC, §289.204, concerning fees for certificates of registration, radioactive material licenses, emergency planning and implementation, and other regulatory services.

Other changes to §289.232 include updating the rules to address the agency's legal requirements to have rules compatible with the Food and Drug Administration, as provided in the Code of Federal Regulations (CFR) on x-ray machine technical requirements; reorganizing current requirements; adding new requirements from staff and stakeholder input; adding and clarifying definitions; and updating terminology. Changes to the section strengthen qualifications for radiation safety officers; require radiation safety officers to review operating and safety procedures at intervals not to exceed 12 months; clarify inspection compliance and hearing procedures; and clarify the requirement for an equipment performance evaluation be performed on radiation machines within 30 days of installation or reinstallation. In addition, the changes clarify timelines and requirements for equipment performance evaluations on the x-ray units; add safety requirements to Operating and Safety Procedures; add requirements for controlling operator's occupational radiation exposure; and strengthen the requirements for digital imaging.

Texas Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Texas Government Code, Chapter 2001 (Administrative Procedure Act). Section 289.232 has been reviewed and DSHS has determined that the reasons for adopting the section continue to exist because a rule on this subject is needed to protect public health and safety and to fulfill DSHS's statutory responsibilities as the state's Radiation Control Agency.

DSHS has solicited comments and recommendations from stakeholders, including the Texas State Board of Dental Examiners (in accordance with Texas Health and Safety Code, §401.064), regarding the draft dental rules. DSHS posted draft rule changes on the Radiation Control web site (www.dshs.texas.gov/radiation). Comments were received from individuals and groups.

A public meeting was held on March 19, 2018, to accept verbal comments. Representatives from the Texas Dental Association; Academia Dental Hygiene Educators; Radiological Systems, Inc.; Texas State Board of Dental Examiners; and Texas Academy of General Dentistry attended. Academia Dental Hygiene Educators and Radiological Systems, Inc. offered comments at the meeting. Comments were reviewed by DSHS Radiation staff and some of the commenters' suggestions were included in the proposed new draft rule.

The Medical Committee of the Texas Radiation Advisory Board (TRAB) reviewed the draft proposed rules at its June 22, 2018, meeting. The TRAB as a whole reviewed the draft proposed rules at its September 28, 2018, meeting and recommended that the proposed repeal and new rule be forwarded to the HHSC Executive Council for consideration.

The rules were presented to the HHSC Executive Council on December 6, 2018. The council received no comments regarding the proposal.

SECTION-BY-SECTION SUMMARY

Section 289.232(a)(1) adds language to update fee requirements located in subsection (h) of this section and §289.204 of this title.

Section 289.232(a)(4) adds language to clarify that the use of radiation machines can only be operated by individuals who have received proper instructions in the safe use of radiation machines.

Section 289.232(b)(5) adds applicable requirements in §289.203 of this title (relating to Notice, Instructions, and Reports to Workers; Inspections), §289.204 of this title (relating to Fees for Certificates of Registration, Radioactive Material Licenses, Emergency Planning and Implementation, and Other Regulatory Services), and §289.205 of this title (relating to Hearing and Enforcement Procedures) to ensure all registrants are complying with agency rules.

Section 289.232(c)(1) and (2), concerning the use of radiation machines, relocates the language previously in subsection (i).

New language in §289.232(c)(3) requires a new prohibition stating that no person can cause the operation of a radiation ma-

chine to result in an exposure of an individual to the useful beam for training, demonstration, or other non-healing arts purposes.

New language in §289.232(c)(4) requires a new prohibition that states an individual cannot hold the tube or tube housing assembly support during a radiographic exposure. Hand-held radiation machines can be held only in the manner specified by the manufacturer recommendation.

Section 289.232(d) does not include the definitions for "Entrance exposure," "Licensed Medical Physicist," "Licensing state," and "Non-certified equipment" from former §289.232(c).

Section 289.232(d) adds new definitions for "Air kerma," "Applicant," "Attenuate," "Committed effective dose equivalent," "Consultant," "Effective dose equivalent," and "Equipment performance evaluations (EPE)."

Section 289.232(d) revises definitions for "Certified radiation machines," "Control panel," "Deep dose equivalent," "Dose," "Dose equivalent," "Dose limits," "Entrance exposure (Entrance air kerma)," "Exposure," "Exposure rate (air kerma rate)," "Gray," "Half-value layer," "Image receptor," "Individual monitoring devices," "Inspection," "Institutional Review Board," "Mobile service operation," "Occupational dose," "Party," "Phototimer," "Protective barrier," "Public dose," and "Radiation machine." The definitions of "Stationary radiation machine" and "Portable radiation machine" were in the previous rule as stand-alone definitions and are moved under "Radiation" to include the different types of radiation machines in one definition. Also, the definitions of "Hand-held radiation machine" and "Mobile radiation machine" are added as new types of radiation machines. The section also revises definitions for "Rem," "Research and development," "Severity level," "Shallow dose equivalent (H_s) (that applies to the external exposure of the skin of the whole body or the skin of an extremity)," "Source of radiation," "Technique chart," "Technique factors," "Total effective dose equivalent," "Worker," "X-ray control panel," and "X-ray field."

Since the section has been renumbered, Figure 25 TAC §289.232(d)(20) replaces the former Figure 25 TAC §289.232(c)(17), Coefficient of variation or C, to reflect the renumbering of the section.

Section 289.232(e)(4) adds language to require that on-site storage is secure from unauthorized use or removal and require that a radiation machine shall meet all requirements of this section before resuming use of the machine for human use.

Section 289.232(e)(6) adds language to require that if a person takes possession of a radiation machine by default of payment and the radiation machine is energized, it shall be in accordance with this chapter.

Section 289.232(e)(8) adds language to clarify that hand-held portable radiation machines shall be held according to manufacturer's specifications.

Section 289.232(e)(10) adds language to specify that registrants are required to perform equipment performance evaluation tests and deletes "Bureau of Radiation Control" and replaces it with "Department of State Health Services, Radiation Control."

Section 289.232(f)(2) deletes the word "telegram" and replaces the word "telefacsimile" with "facsimile."

Section 289.232(h)(1)(A) and (B) replaces the fee "$330" with the language "specified in §289.204 of this title, as amended."

Section 289.232(h)(1)(B)(i) replaces the language "authorized on a single certificate of registration, the registrant will pay an additional $90" with "where radiation machines or services are authorized under the same registration, there will be an additional charge of 30% of the applicable fee."

Section 289.232(h)(1)(B)(ii) removes the language from the previous rule "If this certificate of registration also has additional authorized use sites, the registrant shall pay an additional 30% of the highest fee category."

Section 289.232(h)(1)(C) replaces the language "$330 fee" with "non-refundable fee specified in §289.204 of this title, as amended."

Section 289.232(h)(2)(A) and (B) revises the language to reflect the rule reference concerning fees to "§289.204 of this title, as amended."

Section 289.232(i)(1)(A) adds language to clarify that initial registrations with multiple radiation machine use locations shall complete a separate application for each use location under the registration.

Section 289.232(i)(1)(C) adds language to clarify that the agency may abandon the application and return the original application if it is incomplete 60 days after the submission. Once the application has been abandoned, the applicant will cease use of all radiation machines.

Section 289.232(i)(1)(E) adds language to strengthen the qualifications and specific duties for the radiation safety officer.

Section 289.232(i)(1)(E)(ii)(III)(-f-) replaces the "Texas State Board of Physician Assistant Examiners" with "Texas Physician Assistant Board."

Section 289.232(i)(1)(F) replaces the language "further statements in order to enable the agency" with "additional information."

Section 289.232(i)(1)(H) adds language to specify that an application will not be accepted for filing or processing before the full amount of the fee payment specified in §289.204 of this title.

New §289.232(i)(3)(C) requires the registrant to provide additional information to the agency to determine whether the certificate of registration should be modified.

New §289.232(i)(5)(B) states that the registrant shall designate a qualified individual as the radiation safety officer and shall ensure the individual continually performs the responsibilities of the radiation safety officer.

New §289.232(i)(5)(C) requires persons using radiation machines for mobile services shall have a valid certificate of registration issued by the agency before initiation of the mobile services.

New §289.232(i)(5)(D) requires that for a new certificate of registration, no person shall use radiation machines unless they have applied for registration within 30 days after beginning use of the radiation machine.

New §289.232(i)(5)(F) requires that no person shall provide radiation machine services for a person who does not have evidence of a completed application for registration or a valid certificate of registration issued by the agency except for the initial installation for a new certificate of registration and the registrant is authorized for demonstration and sale of a radiation machine.

Section 289.232(i)(5)(K)(i) revises the required amount of time a loaner radiation machine may be used from 60 days to 30 days.

New §289.232(i)(5)(K)(i)(III) requires the registrant to perform an equipment performance evaluation on loaner radiation machines.

New §289.232(i)(5)(K)(ii) specifies that persons who do not hold a valid certificate of registration may use loaner radiation machines for human use up to 30 days by or under the supervision of a dentist licensed by Texas Board of Dental Examiners, before applying for a certificate of registration.

Section 289.232(i)(6)(A) adds language to require that a written termination request of the certificate of registration shall be signed by the radiation safety officer, owner, or an individual authorized to act on behalf of the registrant.

Section 289.232(i)(8)(G) revises the duration of the reciprocal recognition from one year to two years from the date it is granted. A new request for a reciprocity shall be submitted to the agency every two years and should include the items in §289.232(i)(8)(A).

Section 289.232(j)(2) and (j)(2)(A) adds safety requirements to specify that procedures shall be read by and accessible to each individual prior to operating a radiation machine and reviewed annually not to exceed a 12-month period.

Section 289.232(j)(2)(B)(viii) replaces the language "digital image processing" with "digital imaging acquisition system protocols."

Section 289.232(j)(3)(A)(i)(V) replaces the National Council on Radiation Protection and Measurements (NCRP) language "No. 91 'Recommendations on Limits for Exposure to Ionizing Radiation' (June 1, 1987)" with "No. 116 'Limitation of Exposure to Radiation' (March 31, 1993)."

Section 289.232(j)(3)(A)(v) adds requirements for controlling the operator's occupational radiation exposure.

Figure 25 TAC §289.232(j)(4)(A) replaces former figure 25 TAC §289.232(i)(5)(A) to reflect the renumbering of the section for the radiation caution signs.

Figure 25 TAC §289.232(j)(4)(B)(i)(I) replaces former figure 25 TAC §289.232(i)(5)(B)(iii) to reflect the renumbering of the section for the Form 232-1 for Notice to Employees.

New §289.232(j)(4)(E)(iii) adds language regarding the proper storage of hand-held dental radiation machines.

New §289.232(j)(5)(A)(ii)(I)(-b-) adds language "unless prevented by the design of the certified radiation machine," concerning technique and exposure factors.

Section 289.232(j)(5)(A)(ii)(III), adds the sentence "In addition, a signal audible to the operator shall indicate that the exposure has terminated," concerning technique and exposure factors.

Figure 25 TAC §289.232(j)(5)(E)(i)(I) replaces former figure 25 TAC §289.232(i)(6)(E)(i)(I), the Half-Value Layer for Selected kVp Table, to reflect a new column and data titled, "Intraoral dental systems manufactured before or on June 10, 2006" to compare to the existing column newly titled, "Intraoral dental systems manufactured after June 10, 2006."

New §289.232(j)(5)(J), concerning equipment performance evaluations, relocates the language from previous subsection (b)(3).

New §289.232(j)(5)(J)(i) specifies requirements of an equipment performance evaluation to be performed on radiation machines within 30 days after initial installation or reinstallation of a radiation machine, and after repairs of a radiation machine component that would affect the radiation output.

New figure 25 TAC in §289.232(j)(5)(J)(ii) adds a table to define the requirement for the frequency of an equipment performance evaluation for dental x-ray and CT systems.

New figure 25 TAC in §289.232(j)(5)(J)(x) adds a table for "Radiographic Entrance Exposure Limits (Air Kerma Limits)" to clarify the limits in mR (Exposure Limits) and mGy (Air Kerma Limits).

Section 289.232(j)(5)(J)(xi) adds language to clarify how measurements of the radiation output for a radiation machine shall be performed.

New §289.232(j)(5)(J)(xii) requires registrants to verify and record that all dosimetry equipment meets the requirements of §289.232(j)(5)(J)(xi).

New §289.232(j)(6)(B) adds Title 21, CFR, for the regulation requirements for facilities with radiation machines with investigational device exemptions that are involved in clinical studies.

Section 289.232(j)(8) adds the language "All modifications of components or installation of components must be approved by the manufacturer," concerning radiation machines for dental facilities.

Section 289.232(j)(12)(A) replaces the word "darkroom" with "processing area" for clarification.

Section 289.232(j)(14)(B) adds language to the digital imaging quality assurance/quality control (QA/QC) protocol stating that "if a protocol cannot be established by the manufacturer, it shall be developed and implemented by the registrant."

New §289.232(j)(14)(B)(i) requires that the QA/QC protocol shall include image quality testing for, but not limited to, spatial resolution, noise and contrast by using a commercially purchased testing tool or an inanimate object of at least three varying densities.

New §289.232(j)(14)(B)(i)(I) requires that the QA/QC digital images shall be acquired with each image receptor at an interval not to exceed three months.

New §289.232(j)(14)(B)(i)(II) requires that the QA/QC test images shall be compared to previous test images to assess degradation of image quality.

New §289.232(k)(1)(A) adds language to require registrants to maintain records at each site, including sites authorized by the certificate of registration, conditions, and sites for mobile services. These records may be maintained in electronic format and shall be accessible to radiation machine operators during working hours.

Figure 25 TAC §289.232(k)(1)(K)(i)(II) replaces former figure 25 TAC §289.232(j)(1)(L)(i)(II) to reflect the renumbering of the section for information that falls under an exception to the Texas Public Information Act.

Figure 25 TAC §289.232(k)(2)(A) replaces former figure 25 TAC §289.232(k)(1)(X)(i) to reflect the renumbering of the section and includes the following changes.

Figure 25 TAC §289.232(k)(2)(A)(i), (iii), (vi), (vii), (viii), (xi), (xii) and (xiii) changes language on the time intervals for keeping

records/documents from "Until next on-site inspection" to "Until next routine on-site inspection."

Figure 25 TAC §289.232(k)(2)(A)(iv) adds "25 TAC" to the name of the record/document to state "25 TAC §289.232."

Figure 25 TAC §289.232(k)(2)(A)(viii) adds a new record/document name "Records of machine corrections or repairs."

Figure 25 TAC §289.232(k)(2)(A)(ix), replaces the name of record/document "Equipment Performance Evaluation Tests" with the name of record/document "Equipment Performance Evaluations." Also, the time interval for keeping Equipment Performance Evaluations records/documents is changed from 4 years to 10 years.

Figure 25 TAC §289.232(k)(2)(A)(xi), changes the name of the record/document from "Automatic and Manual Film Processing Records" to "Film Processing Records and Corrections."

Figure 25 TAC §289.232(k)(2)(A)(xii) changes the name of the record/document from "Alternative Film Processing Records" to "Alternative Processing System Records."

Figure 25 TAC §289.232(k)(2)(A)(xiv) changes the name of the record/document from "Records at Additional Authorized Use Locations" to "Records at Additional Authorized Sites."

Section 289.232(k)(3)(B)(i) adds language to clarify that radiation administered for healing arts purposes is an exception to reporting an event involving a radiation machine.

Section 289.232(k)(3)(D)(ii) adds language for registrants to provide an annual written report to each worker of their estimated dose received in that monitoring year if the individual's occupational dose exceeds 100 mrem (1 mSv) total effective dose equivalent or 100 mrem (1mSv) to any individual organ or tissue or the individual requests his or her annual dose report in writing.

Figure 25 TAC §289.232(I)(3)(D)(iii)(II) replaces former figure for 25 TAC §289.232(k)(2)(D)(iii)(II) to reflect the renumbering of the section for Base Administrative Penalties.

Language relating to inspector training is not included in this rule as those training requirements are now detailed in the Radiation Control Program policies and procedures manual.

Other changes to §289.232 correct language in order to be consistent throughout the section and chapter, update rule references, and correct verbiage use and abbreviations for measurements.

FISCAL NOTE

Donna Sheppard, Chief Financial Officer, has determined that for each year of the first five years that the sections are in effect, there will be no fiscal implications to state or local government as a result of enforcing and administering the sections as proposed.

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 employee positions;

(3) implementation of the proposed rules will not require an increase or decrease in future legislative appropriations;

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

(5) the proposed rules will create a new rule, but only to replace the repealed rule;

(6) the proposed new rule will expand and repeal an existing rule;

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

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

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

Donna Sheppard has also determined that there will be no adverse economic impact on small businesses, micro-businesses, or rural communities required to comply with the sections as proposed. Small businesses, micro-businesses, and rural communities will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

COSTS TO REGULATED PERSONS

Texas Government Code, §2001.0045 does not apply to these rules because these rules are necessary to protect the health, safety, and welfare of the residents of Texas.

PUBLIC BENEFIT

Kirk Cole, Interim Associate Commissioner, Consumer Protection Division, has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as the result of enforcing or administering the sections are to ensure continued enhanced protection of the public, patients, workers, and the environment from unnecessary exposure to radiation by ensuring that the rule is clear and specific.

REGULATORY ANALYSIS

DSHS has determined that this proposal is not a "major environmental rule" as defined by Texas Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

DSHS has determined that the proposed repeal and new rule do 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, do not constitute a taking under Texas Government Code, §2007.043.

PUBLIC HEARING

A public hearing to receive comments on the proposal will be scheduled after publication in the *Texas Register* and will be held at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas 78754. The meeting date will be posted on the Radiation Control website

(www.dshs.texas.gov/radiation). Please contact Chuck Flynn at (512) 834-6655, or by email at Chuck.Flynn@dshs.texas.gov if you have questions.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Chuck Flynn, Radiation Unit Manager, Policy, Standards, and Quality Assurance Section, Consumer Protection Division, Texas Department of State Health Services, Mail Code 1987, P.O. Box 149347, Austin, TX 78714-9347; (512) 834-6655 or by email to CPDRuleComments@dshs.texas.gov. Please indicate "Comments on Chapter 289 Proposed Dental Rule" in the subject line.

To be considered, comments must be submitted no later than 30 days following publication of the proposal in the *Texas Register*. If the last day to submit comments falls on a weekend or a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be considered.

For further information, please call: (512) 834-6656.

STATUTORY AUTHORITY

The repeal is authorized by Texas Health and Safety Code, Chapter 401, which provides for DSHS radiation control rules and regulatory program to be compatible with federal standards and regulation; §401.051, which provides the required authority to adopt rules and guidelines relating to the control of sources of radiation; §401.103, which provides authority for licensing and registration for transportation of sources of radiation; §401.224, which provides rulemaking authority relating to the packaging of radioactive waste; and Government Code, §531.0055; and Texas Health and Safety Code, §1001.075, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code, Chapter 1001. The review of the rules implements Texas Government Code, §2001.039, regarding review of existing rules.

The repeal implements Texas Health and Safety Code, Chapters 401 and 1001; and Texas Government Code, Chapter 531.

§289.232. Radiation Control Regulations for Dental Radiation Machines.

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 December 21, 2018.

TRD-201805564
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Earliest possible date of adoption: February 10, 2019
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25 TAC §289.232

STATUTORY AUTHORITY

The new rule is authorized by Texas Health and Safety Code, Chapter 401, which provides for DSHS radiation control rules and regulatory program to be compatible with federal standards and regulation; §401.051, which provides the required authority to adopt rules and guidelines relating to the control of sources of radiation; §401.103, which provides authority for licensing and registration for transportation of sources of radiation; §401.224, which provides rulemaking authority relating to the packaging of radioactive waste; and Government Code, §531.0055; and Texas Health and Safety Code, §1001.075, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code, Chapter 1001. The review of the rules implements Texas Government Code, §2001.039, regarding review of existing rules.

The new rule implements Texas Health and Safety Code, Chapters 401 and 1001; and Texas Government Code, Chapter 531.

§289.232. Radiation Control Regulations for Dental Radiation Machines.

(a) Purpose. This section establishes the requirements for the use of dental radiation machines.

(1) Fees for certificates of registration for dental facilities and provisions for their payment will be processed in accordance with subsection (h) of this section or §289.204 of this title (relating to Fees for Certificates of Registration, Radioactive Material Licenses, Emergency Planning and Implementation, and Other Regulatory Services), as amended.

(2) Requirements of persons using radiation machines are as follows.

(A) No person shall use radiation machines except as authorized in a certificate of registration issued by the agency in accordance with the requirements of this section.

(B) A person who receives, possesses, uses, owns, or acquires radiation machines before receiving a certificate of registration is subject to the requirements of this chapter.

(3) Requirements intended to control the receipt, possession, use, and transfer of radiation machines by any person so the total dose to an individual, including doses resulting from all sources of radiation other than background radiation, does not exceed the standards for protection against radiation prescribed in this chapter. However, nothing in this section shall be construed as limiting actions that may be necessary to protect health and safety in an emergency.

(4) Requirements for the use of radiation machines include that the registrant shall ensure the requirements of this section are met in the operation of such radiation machines and only persons who have received proper instructions in the safe use of radiation machines shall be permitted to operate the radiation machines.

(5) Requirements for specific record keeping and general provisions for records and reports are included in this section.

(6) Requirements for providing notices to employees and instructions and options available to such individuals in connection with agency inspections of registrants to determine compliance with the provisions of the Texas Radiation Control Act, Health and Safety Code, Chapter 401, and requirements of this section, orders, and certificates of registration issued thereunder regarding radiological working conditions.

(7) Governing of the following in accordance with the Texas Radiation Control Act, Health and Safety Code, Chapter 401; the Texas Administrative Procedure Act, Texas Government Code, Chapter 2001; Title 1, Texas Administrative Code, Chapter 155; and the Formal Hearing Procedures, §§1.21, 1.23, 1.25, and 1.27 of this title:

(A) proceedings for the granting, denying, renewing, transferring, amending, suspending, revoking, or annulling of a certificate of registration;

(B) determining compliance with or granting of exemptions from requirements of this section, an order, or a condition of the certificate of registration;

(C) assessing administrative penalties; and

(D) determining propriety of other agency orders.

(b) Scope.

(1) Except as specifically provided in other sections of this chapter, this section applies to persons who receive, possess, use, or transfer dental radiation machines.

(A) The dose limits in this section do not apply to doses due to background radiation, to exposure of patients to radiation for dental diagnosis, to exposure from individuals administered radioactive material and released in accordance with this chapter, or to voluntary participation in medical research programs.

(B) No radiation may be deliberately applied to human beings except by or under the supervision of a dentist licensed by the Texas State Board of Dental Examiners.

(2) Registrants who are also registered by the agency to receive, possess, acquire, transfer, or use class IIIb and class IV lasers in dentistry shall also comply with the requirements of §289.301 of this title (relating to Registration and Radiation Safety Requirements for Lasers and Intense-Pulsed Light Devices).

(3) Dental radiation machines located in a facility that also has other healing arts radiation machines will be inspected at the intervals specified in §289.231(ll)(2) of this title (relating to General Provisions and Standards for Protection Against Machine-Produced Radiation).

(4) The agency may, by requirements in this chapter, an order, or a condition of the certificate of registration, impose upon any registrant such requirements in addition to those established in this section as it deems appropriate or necessary to minimize danger to public health and safety or the environment.

(5) Registrants who are also specifically licensed by the agency to receive, possess, use, and transfer radioactive materials shall also comply with the applicable requirements of §289.201 of this title (relating to General Provisions for Radioactive Material), §289.202 of this title (relating to Standards for Protection Against Radiation from Radioactive Materials), §289.203 of this title (relating to Notice, Instructions, and Reports to Workers; Inspections), §289.204 of this title, §289.205 of this title (relating to Hearing and Enforcement Procedures), §289.252 of this title (relating to Licensing of Radioactive Material), §289.256 of this title (relating to Medical and Veterinary Use of Radioactive Material), and §289.257 of this title (relating to Packaging and Transportation of Radioactive Material).

(c) Prohibitions.

(1) The agency may prohibit use of radiation machines that pose significant threat or endanger occupational and public health and safety, in accordance with subsections (a) - (g) and (l)(3) of this section.

(2) Individuals shall not be exposed to the useful beam except for healing arts purposes authorized by a dentist. This provision specifically prohibits deliberate exposure for the following purposes:

(A) exposure of an individual for training, demonstration, or other non-healing arts purposes; or

(B) exposure of an individual for research except as authorized by subsection (j)(6) of this section.

(3) No person shall cause the operation of a radiation machine that results in exposure of an individual to the useful beam for training, demonstration, or other non-healing arts purposes.

(4) In no case shall an individual hold the tube or tube housing assembly support during any radiographic exposure. Hand-held radiation machines shall be held only in the manner specified by manufacturer recommendation.

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

(1) Absorbed dose--The energy imparted by ionizing radiation per unit mass of irradiated material. The units of absorbed dose are the gray (Gy) and the rad.

(2) Accessible surface--The external surface of the enclosure or housing provided by the manufacturer.

(3) Act--Texas Radiation Control Act, Health and Safety Code, Chapter 401.

(4) Administrative law judge (ALJ)--A judge employed by the State Office of Administrative Hearings.

(5) Administrative penalty--A monetary penalty assessed by the agency in accordance with Health and Safety Code, §401.384, to emphasize the need for lasting remedial action and to deter future violations.

(6) Adult--An individual 18 or more years of age.

(7) Agency--The Department of State Health Services or its successor.

(8) Agreement State--Any state with which the United States Nuclear Regulatory Commission (NRC) has entered into an effective agreement under §274b of the Atomic Energy Act of 1954 (42 United States Code et seq.), as amended (73 Stat. 689).

(9) Air kerma--The kinetic energy released in air by ionizing radiation. Kerma is the quotient of dE by dM, where dE is the sum of the initial kinetic energies of all the charged ionizing particles liberated by uncharged ionizing particles in air of mass dM. The SI unit of air kerma is joule per kilogram and the special name for the unit of kerma is the gray. For purposes of this section, when exposure in air measured in roentgen (R) is to be converted to dose in air measured in gray, a nationally recognized standard air conversion factor shall be used.

(10) Applicant--A person seeking a certificate of registration issued in accordance with the provisions of the Act and the requirements in this section.

(11) As low as is reasonably achievable (ALARA)--Making every reasonable effort to maintain exposures to radiation as far below the dose limits in this section as is practical, consistent with the purpose for which the registered activity is undertaken, taking into account the state of technology, the economics of improvements in relation to the state of technology, the economics of improvements in relation to benefits to the public health and safety, and other societal and socioeconomic considerations, and in relation to utilization of ionizing radiation and radiation machines in the public interest.

(12) Attenuate--To reduce the exposure rate (air kerma rate) upon passage of radiation through matter.

(13) Automatic exposure control--A device that automatically controls one or more technique factors in order to obtain a required quantity of radiation at preselected locations (See definition for phototimer).

(14) Background radiation--Radiation from cosmic sources; non-technologically enhanced naturally occurring radioactive material, including radon, except as a decay product of source or special nuclear material, and including global fallout as it exists in the environment from the testing of nuclear explosive devices or from past nuclear accidents, such as Chernobyl, that contribute to background radiation and are not under the control of the registrant. "Background radiation" does not include radiation from sources of radiation regulated by the agency.

(15) Barrier--(See definition for protective barrier.)

(16) Beam-limiting device--A device that provides a means to restrict the dimensions of the x-ray field.

(17) Beam quality (diagnostic x-ray)--A term that describes the penetrating power of the x-ray beam. This is identified numerically by half-value layer and is influenced by kilovolt peak (kVp) and filtration.

(18) Certificate of registration--A form of permission given by the agency to an applicant who has met the requirements for registration set out in the Act and this chapter.

(19) Certified radiation machines--Radiation machines that have been certified in accordance with Title 21, Code of Federal Regulations (CFR).

(20) Coefficient of variation or C--The ratio of the standard deviation to the mean value of a population of observations. It is estimated using the following equation:
Figure: 25 TAC §289.232(d)(20)

(21) Collective dose--The sum of the individual doses received in a given period by a specified population from exposure to a specified source of radiation.

(22) Commissioner--The Commissioner of the Department of State Health Services.

(23) Committed effective dose equivalent ($H_{E,50}$)--The sum of the products of the weighting factors applicable to each of the body organs or tissues that are irradiated and the committed dose equivalent to these organs or tissues ($H_{E,50} = \Sigma W_T H_{T,50}$).

(24) Contested case--A proceeding in which the agency determines the legal rights, duties, or privileges of a party after an opportunity for adjudicative hearing.

(25) Continuous pressure type switch--A switch so constructed that a circuit closing contact can be maintained only by continuous pressure on the switch by the operator.

(26) Consultant--An individual who is not routinely engaged in work under the registrant who provides advice related to compliance with this chapter.

(27) Control panel--The part of the radiation machine where the switches, knobs, push buttons, and other hardware necessary for manually setting the technique factors are located.

(28) Declared pregnant woman--A woman who has voluntarily informed the registrant, in writing, of her pregnancy and the estimated date of conception. The declaration remains in effect until the declared pregnant woman voluntarily withdraws the declaration in writing or is no longer pregnant.

(29) Deep dose equivalent (H_d), that applies to external whole body exposure--The dose equivalent at a tissue depth of 1 centimeter (1000 milligrams per square centimeter).

(30) Dentist--An individual licensed by the Texas State Board of Dental Examiners.

(31) Diagnostic source assembly--The tube housing assembly with a beam-limiting device attached.

(32) Director--The director of the radiation control program under the agency's jurisdiction.

(33) Dose--A generic term that means absorbed dose, dose equivalent, or total effective dose equivalent. For purposes of this section, "radiation dose" is an equivalent term.

(34) Dose equivalent (H_T)--The product of the absorbed dose in tissue, quality factor, and all other necessary modifying factors at the location of interest. The units of dose equivalent are the sievert (Sv) and rem.

(35) Dose limits--The permissible upper bounds of radiation doses established in accordance with this chapter. For purposes of this section, "limits" is an equivalent term.

(36) Effective dose equivalent (H_E)--The sum of the products of the dose equivalent to the organ or tissue (H_T) and the weighting factors (W_T) applicable to each of the body organs or tissues that are irradiated ($H_E = \Sigma W_T H_T$).

(37) Embryo/fetus--The developing human organism from conception until the time of birth.

(38) Entrance exposure (Entrance air kerma)--The entrance exposure in air expressed in roentgens or the entrance dose in air (air kerma) expressed in gray, measured at the point where the center of the useful beam enters the patient.

(39) Equipment performance evaluations (EPE)--Required testing performed by a registered service provider at a specified interval to ensure radiation machines operate in compliance with this chapter.

(40) Exposure--The quotient of dQ by dm where "dQ" is the absolute value of the total charge of the ions of one sign produced in air when all the electrons (negatrons and positrons) liberated by photons in a volume element of air having mass "dm" are completely stopped in air. The International System of Units (SI) unit of exposure is the coulomb per kilogram. The roentgen is the special unit of exposure. For purposes of this section, this term is used as a noun.

(41) Exposure rate (air kerma rate)--The exposure per unit of time. For purposes of this section, "air kerma rate" is an equivalent term.

(42) External dose--That portion of the dose equivalent received from any source of radiation outside the body.

(43) Extremity--Hand, elbow, arm below the elbow, foot, knee, and leg below the knee. The arm above the elbow and the leg above the knee are considered part of the whole body.

(44) Field emission equipment--Equipment that uses an x-ray tube in which electron emission from the cathode is due solely to the action of an electric field.

(45) Filter--Material placed in the useful beam to absorb selected radiations preferentially.

(46) Gray (Gy)--The SI unit of absorbed dose. One gray is equal to an absorbed dose of one joule per kilogram or 100 rad.

(47) Half-value layer (HVL)--The thickness of a specified material that attenuates the beam of radiation to an extent such that the exposure rate (air kerma rate) is reduced to one-half of its original value.

(48) Healing arts--Any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition.

(49) Hearing--A proceeding to examine an application or other matter before the agency in order to adjudicate rights, duties, or privileges.

(50) Human use--For exposure to x-ray radiation from radiation machines, the external administration of radiation to human beings for healing arts purposes or research or development specifically authorized by the agency.

(51) Image receptor--Any device, such as a fluorescent screen, radiographic film, or digital sensor that transforms incident x-ray photons either into a visible image or into another form that can be made into a visible image by further transformations.

(52) Individual--Any human being.

(53) Individual monitoring--The assessment of dose equivalent to an individual by the use of:

(A) individual monitoring devices; or

(B) survey data.

(54) Individual monitoring devices--Devices designed to be worn by a single individual for the assessment of dose equivalent. For purposes of this section, "personnel dosimeter," "dosimeter," and "personnel monitoring equipment" are equivalent terms. Examples of individual monitoring devices include, but are not limited to, film badges, thermoluminescence dosimeters, optically stimulated luminescence dosimeters, pocket ionization chambers (pocket dosimeters), and electronic personal dosimeters.

(55) Informal conference--A meeting held by the agency with a person to discuss the following:

(A) safety, safeguards, or environmental problems;

(B) compliance with regulatory or registration condition requirements;

(C) proposed corrective measures, including, but not limited to, schedules for implementation; and

(D) enforcement options available to the agency.

(56) Inspection--An official thorough examination or observation, including, but not limited to, records, tests, surveys, and monitoring to effectively determine compliance with the Act and requirements of this section, orders, and conditions of the agency.

(57) Institutional Review Board (IRB)--Any board, committee, or other group formally designated by an institution to review, approve the initiation of, and conduct periodic review of biomedical research involving human subjects.

(58) Ionizing radiation--Any electromagnetic or particulate radiation capable of producing ions, directly or indirectly, in its passage through matter. Ionizing radiation includes gamma rays and x-rays, alpha and beta particles, high-speed electrons, neutrons, and other nuclear particles.

(59) kV--Kilovolt.

(60) kVp--Kilovolt peak (See definition for peak tube potential).

(61) kWs--Kilowatt-second. It is equivalent to 10 E 3 watt-second, where 1 watt-second =1 kilovolt x 1 milliampere x 1 second.

(62) Lead equivalent--The thickness of lead affording the same attenuation, under specified conditions, as the material in question.

(63) Leakage radiation--Radiation emanating from the diagnostic assembly except for the useful beam and radiation produced when the exposure switch or timer is not activated.

(64) Lens dose equivalent--The external dose equivalent to the lens of the eye at a tissue depth of 0.3 centimeters (300 milligrams per square centimeter).

(65) License--A form of permission given by the agency to an applicant who has met the requirements for licensing set out in the Act and this chapter.

(66) Licensed material--Radioactive material received, possessed, used, or transferred under a general or specific license issued by the agency.

(67) Licensee--Any person who is licensed by the agency in accordance with the Act and this chapter.

(68) mA--Milliampere.

(69) mAs--Milliampere-second.

(70) Medical research--The investigation of various health risks and diseases.

(71) Member of the public--Any individual, except when that individual is receiving an occupational dose.

(72) Minor--An individual less than 18 years of age.

(73) Mobile service operation--The provision of radiation machines and personnel at temporary locations for limited time periods.

(74) Monitoring--The measurement of radiation and the use of the results of these measurements to evaluate potential exposures and doses. For purposes of this section, "radiation monitoring" and "radiation protection monitoring" are equivalent terms.

(75) Notice of violation--A written statement prepared by the agency of one or more alleged infringements of a legally binding requirement.

(76) Occupational dose--The dose received by an individual in the course of employment in which the individual's assigned duties involve exposure to radiation from licensed/registered and unlicensed/unregistered sources of radiation, whether in the possession of the licensee/registrant or other person. Occupational dose does not include dose received from background radiation, from any medical administration the individual has received, from exposure to individuals administered radioactive material and released in accordance with this section, from voluntary participation in medical research programs, or as a member of the public.

(77) Order--A specific directive contained in a legal document issued by the agency.

(78) Party--A person designated as such by the ALJ. A party may consist of the following:

(A) the agency;

(B) an applicant, licensee, registrant, accredited mammography facility, or certified industrial radiographer; and

(C) any person affected.

(79) Patient--An individual subjected to dental examination, diagnosis, or treatment.

(80) Peak tube potential--The maximum value of the potential difference in kilovolts across the x-ray tube during an exposure.

(81) Person--Any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency, local government, any other state or political subdivision or agency thereof, or any other legal entity, and any legal successor, representative, agent, or agency of the foregoing, other than the United States Nuclear Regulatory Commission, and other than federal government agencies licensed or exempted by the United States Nuclear Regulatory Commission.

(82) Personnel monitoring equipment--(See definition for individual monitoring devices).

(83) Phototimer--A method for controlling radiation exposures to image receptors by the amount of radiation that reaches a radiation detection device. The radiation detection device is part of an electronic circuit that controls the duration of time the tube is activated (See definition for automatic exposure control).

(84) Primary protective barrier--(See definition for protective barrier).

(85) Protective barrier--A barrier of radiation absorbing materials used to reduce radiation exposure. The types of protective barriers are as follows:

(A) primary protective barrier--A barrier sufficient to attenuate the useful beam to the required degree; or

(B) secondary protective barrier--A barrier sufficient to attenuate the stray radiation to the required degree.

(86) Public dose--The dose received by a member of the public from exposure to radiation from licensed/registered and unlicensed/unregistered sources of radiation, whether in the possession of the licensee/registrant or other person. It does not include occupational dose or doses received from background radiation, from any medical administration the individual has received, from exposure to individuals administered radioactive material and released in accordance with this section, or from voluntary participation in medical research programs, or as a member of the public.

(87) Rad--The special unit of absorbed dose. One rad is equal to an absorbed dose of 100 ergs per gram or 0.01 joule per kilogram (0.01 Gy).

(88) Radiation--One or more of the following:

(A) gamma and x-rays, alpha and beta particles, and other atomic or nuclear particles or rays;

(B) radiation emitted to energy density levels that could reasonably cause bodily harm from an electronic device; or

(C) sonic, ultrasonic, or infrasonic waves from any electronic device or resulting from the operation of an electronic circuit in an electronic device in the energy range to reasonably cause detectable bodily harm.

(89) Radiation area--Any area, accessible to individuals, in which radiation levels could result in an individual receiving a dose equivalent in excess of 0.005 rem (0.05 millisievert) in one hour at 30 centimeters from the radiation machine or from any surface that the radiation penetrates.

(90) Radiation machine--An x-ray system, subsystem, or component capable of producing ionizing radiation except those devices with radioactive material as the only source of radiation. For purposes of this section, "radiation machine," "x-ray equipment," "x-ray system," and "x-ray unit" are equivalent terms. Types of radiation machines include, but are not limited to:

(A) Stationary radiation machine--A radiation machine that is installed in a fixed location.

(B) Hand-held radiation machine--A radiation machine that is designed to be hand-held during operation.

(C) Portable radiation machine--A radiation machine that is mounted on a permanent base with wheels or casters for moving while completely assembled, including a hand-carried radiation machine that is designed to be mounted on a support while operating.

(D) Mobile radiation machine--A radiation machine that is transported in a vehicle to be used at various temporary locations.

(91) Radiation safety officer (RSO)--An individual who has a knowledge of and the authority and responsibility to apply appropriate radiation protection rules, standards, and practices, who shall be specifically authorized on a certificate of registration, and who is the primary contact with the agency.

(92) Radiograph--An image receptor on which the image is created directly or indirectly by an x-ray exposure and results in a permanent record.

(93) Registrant--Any person issued a certificate of registration by the agency in accordance with the Act and this chapter.

(94) Regulation--(See definition for rule).

(95) Rem--The special unit of any of the quantities expressed as dose equivalent. The dose equivalent in rem (sievert (Sv) is equal to the absorbed dose in rad or gray multiplied by the quality factor (1 rem = 0.01 Sv).

(96) Remote inspection--An examination by the agency of information submitted by the registrant on a form provided by the agency.

(97) Research and development--Research and development is defined as:

(A) theoretical analysis, exploration, or experimentation; or

(B) the extension of investigative findings and theories of a scientific or technical nature into practical application for experimental and demonstration purposes, including the experimental production and testing of models, devices, equipment, radiation machines, materials, and processes.

(98) Restricted area--An area, access to which is limited by the registrant for protecting individuals against undue risks from exposure to radiation. Restricted area does not include areas used as residential quarters, but separate rooms in a residential building may be set apart as a restricted area.

(99) Roentgen (R)--The special unit of exposure. One roentgen (R) equals 2.58 x 10^{-4} coulombs per kilogram of air. (See definition for exposure.)

(100) Rule--Any agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedure or practice requirements of an agency. The term includes the amendment or repeal of a section but does not include statements con-

cerning the internal management or organization of any agency and does not affect private rights or procedures. The word "rule" was formerly referred to as "regulation."

(101) Scattered radiation--Radiation that has been deviated in direction during passage through matter.

(102) Secondary protective barrier--(See definition for protective barrier).

(103) Severity level--A classification of violations based on relative seriousness of each violation and the significance of the effect of the violation on the occupational or public health or safety or the environment.

(104) Shallow dose equivalent (H_s) (that applies to the external exposure of the skin of the whole body or the skin of an extremity)--The dose equivalent at a tissue depth of 0.007 centimeters (7 milligrams per square centimeter).

(105) SI--The abbreviation for the International System of Units.

(106) Sievert--The SI unit of any of the quantities expressed as dose equivalent. The dose equivalent in sievert is equal to the absorbed dose in gray multiplied by the quality factor (1 sievert = 100 rem).

(107) Source of radiation--Any radioactive material or device that is capable of emitting or producing ionizing radiation.

(108) Source-to-image receptor distance--The distance from the source to the center of the input surface of the image receptor.

(109) Source-to-skin distance--The distance from the source to the skin of the patient.

(110) Special units--The conventional units historically used by registrants, i.e., rad (absorbed dose), and rem (dose equivalent).

(111) Stray radiation--The sum of leakage and scattered radiation.

(112) Supervision--The delegating of the task of applying radiation in accordance with this section to persons not licensed in dentistry, who perform tasks under the dentist's control. The dentist assumes full responsibility for these tasks and shall assure that the tasks will be administered correctly.

(113) Survey--An evaluation of the radiological conditions and potential hazards incident to the production, use, transfer, and disposal of radiation machines. When appropriate, such survey includes, but is not limited to, tests, physical examination of location of equipment or radiation machines, and measurements of levels of radiation present, and evaluation of administrative and engineered controls.

(114) Technique chart--A chart that provides technical factors, anatomical examination, and patient size for examination being performed needed to make clinical radiographs when the radiation machine is in manual mode.

(115) Technique factors--The conditions of operation that are specified as follows:

(A) for capacitor energy storage equipment, peak tube potential in kilovolt and quantity of charge in milliampere-second;

(B) for field emission equipment rated for pulsed operation, peak tube potential in kilovolt and number of x-ray pulses; and

(C) for all other radiation machines, peak tube potential in kilovolt and either tube current in milliamperes and exposure time in seconds or the product of tube current and exposure time in milliampere-second.

(116) Termination--A release by the agency of the obligations and authorizations of the registrant under the terms of the certificate of registration. It does not relieve a person of duties and responsibilities imposed by law or rule.

(117) Texas Regulations for Control of Radiation--All sections of Chapter 289 of this title.

(118) Total effective dose equivalent--The sum of the effective dose equivalent (for external exposures) and the committed effective dose equivalent (for internal exposures).

(119) Traceable to a national standard--This indicates that a quantity or a measurement has been compared to a national standard, for example, the National Institute of Standards and Technology, directly or indirectly through one or more intermediate steps and that all comparisons have been documented.

(120) Tube--An x-ray tube, unless otherwise specified.

(121) Tube housing assembly--The tube housing with tube installed. It includes high-voltage and/or filament transformers and other appropriate elements when such are contained within the tube housing.

(122) Unrestricted area (uncontrolled area)--An area, access to which is neither limited nor controlled by the registrant. For purposes of this section, "uncontrolled area" is an equivalent term.

(123) Useful beam--Radiation that passes through the window, aperture, core, or other collimating device of the source housing. Also referred to as the primary x-ray beam.

(124) Violation--An infringement of any rule, license or registration condition, order of the agency, or any provision of the Act.

(125) Whole body--For purposes of external exposure, head, trunk, including male gonads, arms above the elbow, or legs above the knee.

(126) Worker--An individual engaged in work under the certificate of registration issued by the agency.

(127) X-ray control panel--A device that controls input power to the x-ray high-voltage generator or the x-ray tube. It includes components such as timers, phototimers, automatic brightness stabilizers, and similar devices that control the technique factors of an x-ray exposure.

(128) X-ray field--That area of the intersection of the useful beam and any one of the set of planes parallel to and including the plane of the image receptor, whose perimeter is the locus of points at which the exposure rate (air kerma rate) is one-fourth of the maximum in the intersection.

(129) X-ray high-voltage generator--A device that transforms electrical energy from the potential supplied by the x-ray control to the tube operating potential. The device may also include means for transforming alternating current to direct current, filament transformers for the x-ray tubes, high-voltage switches, electrical protective devices, and other appropriate elements.

(130) X-ray system--An assemblage of components for the controlled production of x-rays. It includes, minimally, an x-ray high-voltage generator, an x-ray control, a tube housing assembly, a beam-limiting device, and the necessary supporting structures. Additional components that function with the system are considered integral parts of the system.

(131) X-ray subsystem--Any combination of two or more components of an x-ray system.

(132) X-ray tube--Any electron tube that is designed to be used primarily for the production of x-rays.

(133) Year--The period of time beginning in January used to determine compliance with the provisions of this chapter. The registrant may change the starting date of the year used to determine compliance by the registrant if the change is made at the beginning of the year and that no day is omitted or duplicated in consecutive years.

(e) Exemptions.

(1) The agency may, upon application or upon its own initiative, exempt a source of radiation or a kind of use or user from the requirements of this section if the agency determines that the law does not prohibit the exemption and it will not result in a significant risk to public health or safety or the environment. In determining such exemptions, the agency will consider:

(A) state of technology;

(B) economic considerations in relation to benefits to the public health and safety; and

(C) other societal, socioeconomic, or public health and safety considerations.

(2) Electronic equipment that produces radiation incidental to its operation for other purposes is exempt from the registration and notification requirements of this section, if the dose equivalent rate averaged over an area of 10 square centimeters does not exceed 0.5 millirem (5 microsieverts) per hour at 5 centimeters from any accessible surface of such equipment. The production, testing, or factory servicing of such equipment shall not be exempt.

(3) Radiation machines in transit or in storage incident to transit are exempt from the requirements of this section. This exemption does not apply to the providers of radiation machines for mobile services.

(4) Facilities that have placed all radiation machines in storage, including on-site storage secured from unauthorized use or removal, and have notified the agency in writing, are exempt from the requirements of this section. This exemption is void if any radiation machine is energized resulting in the production of radiation. Before resuming use of the radiation machine for human use, the radiation machine shall meet all requirements of this section.

(5) Inoperable radiation machines are exempt from the requirements of this section. For the purposes of this section, an inoperable radiation machine means a radiation machine that cannot be energized when connected to a power supply without repair or modification.

(6) A person that takes possession of a radiation machine as the result of foreclosure, bankruptcy, or other default of payment may possess the radiation machine without registering it. If the radiation machine is energized, it shall be in accordance with this chapter.

(7) No individual monitoring shall be required for personnel operating only dental radiation machines for dental diagnostic purposes.

(8) Portable radiation machines designed to be hand-held are exempt from the requirements of subsections (c)(4) and (j)(5)(C) of this section. The portable radiation machines shall be held according to manufacturer's specifications.

(9) Individuals who are sole practitioners and sole operators, and the only occupationally exposed individual are exempt from the following requirements:

(A) operating and safety procedures specified in subsection (j)(2) of this section;

(B) instruction to workers specified in subsection (j)(3)(D) of this section; and

(C) posting of notices to workers specified in subsection (j)(4)(B) and (C) of this section.

(10) In accordance with Texas Occupations Code, §258.054, dental practices are exempt from the Medical Physics Practice Act, Texas Occupations Code, Chapter 602. Registrants required to have EPE tests performed in accordance with subsection (j)(5)(J) of this section may select any qualified person authorized by registration through the Department of State Health Services, Radiation Control.

(f) Communications.

(1) Except where otherwise specified, all communications and reports concerning this chapter and applications filed under the communications and reports should be mailed by postal service to Radiation Control, Department of State Health Services, P.O. Box 149347, MC 2003, Austin, Texas, 78714-9347. Communications, reports, and applications may be delivered in person to the agency's office located at 8407 Wall Street, Austin, Texas, 78754.

(2) Documents received by the agency will be deemed to have been received on the date of the postmark, facsimile, or other electronic media transmission.

(g) Interpretations. Except as specifically authorized by the agency in writing, no interpretation of the meaning of this chapter by any officer or employee of the agency other than a written legal interpretation by the agency, will be considered binding upon the agency.

(h) Fees for certificates of registration for dental facilities.

(1) Payment of fees.

(A) Each application for a certificate of registration shall be accompanied by a nonrefundable fee specified in §289.204 of this title, as amended. No application will be accepted for filing or processed before payment of the full amount specified.

(B) A nonrefundable fee specified in §289.204 of this title, as amended, shall be paid for each certificate of registration for radiation machines used in dentistry. The fee shall be paid every two years and shall be paid in full and on or before the due date stated on the invoice.

(i) For each additional use location where radiation machines or services are authorized under the same registration, there will be an additional charge of 30% of the applicable fee.

(ii) In the case of a single certificate of registration that authorizes more than one category of radiation machine use, the category listed in §289.204 of this title that is assigned the higher fee will be used.

(C) Each application for reciprocal recognition of an out-of-state registration in accordance with subsection (i)(8) of this section shall be accompanied by the non-refundable fee specified in §289.204 of this title, as amended, provided that no such fee has been submitted within 24 months of the date of commencement of the proposed activity.

(D) Fee payments shall be in cash or by check or money order made payable to the Department of State Health Services. The payments may be made by personal delivery to the central office, Radiation Control, Department of State Health Services, 1100 West 49th Street, Austin, Texas, 78756-3199 or mailed to Radiation Control, De-

partment of State Health Services, P.O. Box 149347, MC 2003, Austin, Texas, 78714-9347.

(2) Failure to pay prescribed fees.

(A) In any case where the agency finds that an applicant for a certificate of registration has failed to pay the non-refundable fee prescribed in §289.204 of this title, as amended, the agency will not process that application until such fee is paid.

(B) In any case where the agency finds that a registrant has failed to pay a fee prescribed by §289.204 of this title, as amended, by the due date, the agency may implement compliance procedures as provided in subsection (l)(3)(C) of this section.

(3) Electronic fee payments. Renewal payments may be processed through www.texas.gov or another electronic payment system specified by the agency. For all types of electronic fee payments, the agency will collect additional fees, in amounts determined by www.texas.gov to recover costs associated with electronic payment processing.

(i) Registration of radiation machine use.

(1) Application for registration of radiation machines.

(A) Application for registration shall be completed on forms prescribed by the agency and shall contain all the information required by the form and accompanying instructions. For initial registrations with multiple radiation machine use locations, a separate application shall be completed for each use location under the registration.

(B) Each person having a radiation machine used in dentistry shall apply for registration with the agency within 30 days after beginning use of the radiation machine, except for mobile services that shall be registered in accordance with paragraph (2) of this subsection and clinical trial evaluations that shall be registered in accordance with paragraph (5)(K) of this subsection.

(C) If the application is incomplete 60 days after submission, the agency may abandon the application and return the original application. The applicant will cease use of all radiation machines once the application has been abandoned.

(D) The applicant shall ensure that radiation machines will be operated by individuals qualified by reason of training and experience to use the radiation machines for the purpose requested in accordance with this section in such a manner as to minimize danger to occupational and public health and safety.

(E) A radiation safety officer shall be designated on each application form. The qualifications of that individual shall be submitted to the agency with the application. The radiation safety officer shall meet the applicable qualifications of clause (i) of this subparagraph and carry out the responsibilities specified in clause (v) of this subparagraph.

(i) The radiation safety officer shall have the following qualifications:

(I) knowledge of potential hazards and emergency precautions; and

(II) educational courses completed that relate to ionizing radiation safety or a radiation safety officer course; or

(III) experience in the use and familiarity of the type of radiation machine used; and

(ii) In addition to the qualifications in clause (i) of this subparagraph, documentation of the following shall be submitted to the agency:

(I) for dentist radiation safety officers, a dental licensing board number and their signature on the application;

(II) for a practitioner radiation safety officer, documentation of a licensing board number; or

(III) for non-practitioner radiation safety officers, any one of the following:

(-a-) evidence of a valid general certificate issued under the Medical Radiologic Technologist Certification Act, Texas Occupations Code, Chapter 601, and at least two years of supervised experience or supervised use of radiation machines;

(-b-) evidence of a valid limited general certificate issued under the Medical Radiologic Technologist Certification Act, Texas Occupations Code, Chapter 601, and at least four years of supervised experience or supervised use of radiation machines;

(-c-) evidence of registry by the American Registry of Radiologic Technologists and at least two years of supervised experience or supervised use of radiation machines;

(-d-) evidence of associate degree in radiologic technology, health physics, or nuclear technology, and at least two years of supervised experience or supervised use of radiation machines;

(-e-) evidence of registration with the Texas Board of Nursing as a Registered Nurse and at least two years of supervised experience or supervised use of radiation machines in the respective specialty;

(-f-) evidence of registration with the Texas Physician Assistant Board, and at least two years of supervised use of radiation machines in the respective specialty;

(-g-) evidence of:

(-1-) registration with the Texas State Board of Dental Examiners to perform radiologic procedures under a dentist's instruction and direction or evidence of a valid certificate as a registered dental hygienist; and

(-2-) at least four years of supervised use of radiation machines in the respective dentist's specialty;

(-h-) evidence of bachelor's (or higher) degree in a natural or physical science, health physics, radiological science, nuclear medicine, or nuclear engineering; or

(-i-) evidence of a current Texas license under the Medical Physics Practice Act, Texas Occupations Code, Chapter 602, in medical health physics, diagnostic medical physics, or nuclear medical physics for diagnostic x-ray facilities.

(iii) Academic institutions and research and development facilities shall have radiation safety officers who are faculty or staff members in radiation protection, radiation engineering, or related disciplines. (This individual may also serve as the radiation safety officer over the dental section of the facility.)

(iv) The radiation safety officer identified on a certificate of registration for use of dental radiation machines issued before September 1, 1993, need not comply with the qualification requirements in this subsection.

(v) Specific duties of the radiation safety officer include, but are not limited to, the following:

(I) establishing and overseeing operating and safety procedures that maintain radiation exposures as low as reasonably achievable, and reviewing the procedures at intervals not to exceed 12 months to ensure that the procedures are current and conform with this section;

(II) investigating and reporting to the agency each:

(-a-) known or suspected case of radiation exposure to an individual or radiation level detected in excess of limits established by this section; and

(-b-) theft or loss of radiation machines, determining the cause, and taking steps to prevent its recurrence;

(III) assuming control and having the authority to institute corrective actions, including shutdown of operations when necessary in emergencies or unsafe conditions;

(IV) making and maintaining records as required by this section; and

(V) ensuring that personnel are adequately trained and complying with this section, the conditions of the certificate of registration, and the operating and safety procedures of the registrant.

(F) At any time after the filing of the original application, the agency may require additional information to determine whether the certificate of registration is issued or denied.

(G) An application for a certificate of registration may include a request for a certificate of registration authorizing one or more activities or radiation machine use locations. If an application includes a request for an additional authorization other than use of a dental radiation machine, compliance with other applicable sections of this chapter will be required.

(H) Each application for a certificate of registration shall be accompanied by the fee prescribed in §289.204 of this title, as amended. No application will be accepted for filing or processed before payment of the full amount specified.

(I) Each application shall be accompanied by a completed RC Form 226-1, Business Information Form that shall contain the legal name of the entity or business. The form can be found at http://dshs.texas.gov/radiation/x-ray/medical-faq.aspx. Unless exempt in accordance with the Business and Commerce Code, Chapter 71, the applicant shall:

(i) be authorized to conduct business in the State of Texas as listed on the Texas Secretary of State (SOS) website; and

(ii) file an assumed name certificate with the Texas SOS if using an assumed name in their application or the office of the county clerk in the county where the business is located.

(J) An application for use of a dental radiation machine shall be signed by a licensed dentist. The signature of the administrator, president, or chief executive officer will be accepted in lieu of a licensed dentist's signature if the facility has more than one licensed dentist who may direct the operation of radiation machines. The application shall also be signed by the radiation safety officer.

(K) Applications and documents submitted to the agency may be made available for public inspection except that the agency may withhold any document or part thereof from public inspection in accordance with subsection (k)(1)(J) and (K) of this section.

(2) Application for registration of mobile service operation used in dentistry. In addition to the requirements of paragraph (1) of this subsection, each applicant shall apply for and receive authorization from the agency for mobile service operation before beginning mobile service operation. The following shall be submitted:

(A) An established main location where the radiation machines and related compliance documents and records will be maintained for inspection. This shall be a street address, not a post office box number.

(B) A sketch or description of the normal configuration of each radiation machine's use, including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed radiation machine inside, furnish the floor plan indicating protective shielding and the operator's position.

(C) A current copy of the applicant's operating and safety procedures regarding radiological practices for protection of patients, operators, employees, and the public.

(3) Issuance of certificate of registration.

(A) A certificate of registration will be approved if the agency determines that an application meets the requirements of the Act and the requirements of this chapter. The certificate of registration authorizes the proposed activity and contains the conditions and limitations, as the agency deems appropriate or necessary.

(B) The agency may incorporate in the certificate of registration at the time of issuance, or thereafter by amendment, additional requirements and conditions concerning the registrant's possession, use, and transfer of radiation machines subject to this chapter, as it deems appropriate or necessary in order to:

(i) minimize danger to occupational and public health and safety;

(ii) require additional records and the keeping of additional records as may be appropriate or necessary; and

(iii) prevent loss or theft of radiation machines subject to this chapter.

(C) The agency may request, and the registrant shall provide, additional information after the certificate of registration has been issued to enable the agency to determine whether the certificate of registration should be modified in accordance with paragraph (7) of this subsection.

(4) Terms and conditions of certificates of registration.

(A) Each certificate of registration issued in accordance with this section shall be subject to the applicable provisions of the Act, now or hereafter in effect, and to the applicable requirements of this chapter and orders of the agency.

(B) No certificate of registration issued or granted under this section shall be transferred, assigned, or in any manner disposed of, either voluntarily or involuntarily, to any person unless the agency authorizes the transfer in writing.

(C) Each person registered by the agency for radiation machine use in accordance with this section shall confine use and possession of the radiation machine registered to the locations and purposes authorized in the certificate of registration.

(D) In making a determination whether to grant, deny, amend, revoke, suspend, or restrict a certificate of registration, the agency may consider the technical competence and compliance history of an applicant or holder of a certificate of registration. After an opportunity for a hearing, the agency shall deny an application for a certificate of registration or an amendment to a certificate of registration if the applicant's compliance history reveals that at least three agency actions have been issued against the applicant, within the previous six years, that assess administrative or civil penalties against the applicant, or that revoke or suspend the certificate of registration.

(5) Responsibilities of the registrant.

(A) The registrant is responsible for complying with this section and the conditions of the certificate of registration.

(B) The registrant shall designate an individual qualified in accordance with paragraph (1)(E)(i) of this subsection as the radiation safety officer and shall ensure the individual continually performs the duties of the radiation safety officer as identified in paragraph (1)(E)(v) of this subsection.

(C) Persons using radiation machines in accordance with subsection (i)(2) of this section, concerning application for mobile services, shall have a valid certificate of registration issued by the agency before initiation of the mobile services.

(D) Other than the initial installation of the first radiation machine for a new certificate of registration, no person shall use a radiation machine unless the person has applied for registration within 30 days after beginning use of the radiation machine in accordance with subsection (i)(1)(B) of this section.

(E) No registrant shall engage any person for services described in §289.226(b)(11) of this title (relating to Registration of Radiation Machine Use and Services) until such person provides to the registrant evidence of registration with the agency.

(F) No person shall provide radiation machine services for a person who cannot produce evidence of a completed application for registration or a valid certificate of registration issued by the agency except for:

(i) the initial installation of the first radiation machine for a new certificate of registration; and

(ii) the registrant authorized for demonstration and sale may demonstrate a radiation machine in accordance with paragraph (5)(D) of this subsection, except as prohibited by subsection (c) of this section.

(G) The registrant shall notify the agency in writing of any changes that would render the information contained in the application for registration or the certificate of registration inaccurate. The notification shall be in writing and signed by an authorized representative.

(i) Notification is required within 30 days after the following changes:

(I) legal business name;

(II) mailing address;

(III) street address where radiation machine will be used;

(IV) additional radiation machine location;

(V) radiation safety officer; or

(VI) name and registration number of the contracted "provider of equipment," registered in accordance with §289.226 of this title.

(ii) The registrant shall notify the agency within 30 days after changes in the radiation machines that include:

(I) any change in the category of radiation machine type or type of use as authorized in the certificate of registration (for example, addition of a computerized tomography radiation machine); or

(II) any increase in the number of radiation machines authorized by the certificate of registration in any radiation machine type or type of use category.

(H) The registrant, or the parent company, shall notify the agency, in writing, immediately following the filing of a voluntary or involuntary petition for bankruptcy. This notification shall include:

(i) the bankruptcy court in which the petition for bankruptcy was filed; and

(ii) the case name and number, and date of filing the petition.

(I) The registrant shall inventory all radiation machines in the registrant's possession at an interval not to exceed one year.

(i) The inventory shall include:

(I) manufacturer's name;

(II) model and serial number of the control panel; and

(III) location of all radiation machines, for example, room number.

(ii) Records of the inventory shall be made and maintained in accordance with subsection (k)(2) of this section for inspection by the agency.

(J) Receipt, transfer, and disposal of radiation machines.

(i) The registrant shall make and maintain records of receipt, transfer, and disposal of radiation machines. The records shall include the following:

(I) manufacturer's name and model and serial number from the control panel;

(II) date of the receipt, transfer, and disposal;

(III) name and address of person the radiation machines received from, transferred to, or disposed of; and

(IV) name of the individual recording the information.

(ii) Records of receipt, transfer, and disposal of radiation machines shall be made and maintained in accordance with subsection (k)(2) of this section for inspection by the agency.

(K) The following criteria applies to loaner radiation machines.

(i) For persons having a valid certificate of registration, loaner radiation machines may be used for up to 30 days. If the loaner radiation machine is used for more than 30 days, the registrant is required, within the next 30 days, to complete the following:

(I) notify the agency of any change in the category of radiation machine type or type of use as authorized in the certificate of registration (for example, addition of a computerized tomography radiation machine); or

(II) notify the agency of any increase in the number of radiation machines authorized by the certificate of registration in any radiation machine type or type of use category; and

(III) perform an EPE on the radiation machines in accordance with subsection (j)(5)(J) of this section.

(ii) For persons who do not hold a valid certificate of registration, loaner radiation machines may be used for human use up to 30 days, by or under the supervision of a dentist licensed by Texas State Board of Dental Examiners, before applying for a certificate of registration in accordance with this section.

(6) Termination of certificates of registration. When a registrant decides to terminate all activities involving radiation machines authorized under the certificate of registration, the registrant shall notify the agency immediately and:

(A) request termination of the certificate of registration in writing. The request shall be signed by the radiation safety officer, owner, or an individual authorized to act on behalf of the registrant;

(B) submit to the agency a record of the disposition of the radiation machines and, if transferred, to whom transferred; and

(C) pay any outstanding fees in accordance with subsection (h) of this section.

(7) Modification, suspension, and revocation of certificates of registration.

(A) The terms and conditions of all certificates of registration shall be subject to revision or modification. A certificate of registration may be suspended or revoked by reason of amendments to the Act, by reason of requirements of this chapter or orders issued by the agency.

(B) Any certificate of registration may be revoked, suspended, or modified, in whole or in part in accordance with subsection (l)(3)(C)(iii) of this section.

(C) Each certificate of registration revoked by the agency ends at the end of the day on the date of the agency's final determination to revoke the certificate of registration, or on the revocation date stated in the determination, or as otherwise provided by the agency order.

(D) Except in cases in which the occupational and public health or safety requires otherwise, no certificate of registration shall be suspended or revoked unless, before the institution of proceedings therefore, facts or conduct that may warrant such action shall have been called to the attention of the registrant in writing and the registrant shall have been afforded an opportunity to demonstrate compliance with all lawful requirements.

(8) Reciprocal recognition of out-of-state certificates of registration.

(A) Whenever any radiation machine is to be brought into the State of Texas for any temporary use, the person proposing to bring the radiation machine into the state shall apply for and receive a notice from the agency granting reciprocal recognition before beginning operations. The request for reciprocity shall include the following:

(i) completed RC Form 226-1 (Business Information Form);

(ii) completed RC Form 252-3 (Notice of Intent to Work in Texas Under Reciprocity);

(iii) name and Texas licensing board number of the dentist if the radiation machines are used on humans;

(iv) copy of the applicant's current state certificate of registration or equivalent document;

(v) copy of the applicant's current operating and safety procedures pertinent to the proposed use;

(vi) fee as specified in subsection (h)(1) of this section; and

(vii) qualifications of personnel who will be operating the radiation machines.

(B) Upon a determination that the request for reciprocity meets the requirements of the agency, the agency may issue a notice granting reciprocal recognition authorizing the proposed radiation machine use.

(C) Once reciprocity is granted, the out-of-state registrant shall file a RC Form 252-3 with the agency before each entry into the state. This form shall be filed at least three working days before the radiation machine is used in the state. At determination of the agency, the out-of-state registrant may, for a specific case, obtain permission to proceed sooner if the three-day period would impose an undue hardship.

(D) When radiation machines are used as authorized under reciprocity, the out-of-state registrant shall have the following in its possession at all times for inspection by the agency:

(i) completed RC Form 252-3;

(ii) copy of the notice from the agency granting reciprocity;

(iii) copy of the out-of-state registrant's operating and safety procedures; and

(iv) copy of the applicable rules as specified in the notice granting reciprocity.

(E) If the state from which the radiation machine is proposed to be brought does not issue certificates of registration or equivalent documents, a certificate of registration shall be obtained from the agency in accordance with the requirements of this section.

(F) The agency may withdraw, limit, or qualify its acceptance of any certificate of registration or equivalent document issued by another agency upon determining that such action is necessary in order to prevent undue hazard to occupational and public health and safety or property or environment.

(G) Reciprocal recognition will expire two years from the date it is granted. A new request for reciprocity shall be submitted to the agency every two years and the items in subparagraph (A) of this paragraph shall be included.

(H) Radiation services provided by a person from out-of-state will not be granted reciprocity. Whenever radiation services are to be provided by a person from out-of-state, that person shall apply for and receive a certificate of registration from the agency before providing radiation services. The application shall be filed in accordance with this subsection, as applicable.

(j) Use of radiation machines.

(1) As low as reasonably achievable. Persons shall use, to the extent practical, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and public doses that are as low as reasonably achievable.

(2) Operating and safety procedures. Each registrant shall have and implement written operating and safety procedures. These procedures shall be read by and accessible to each individual before operating a radiation machine, including any restrictions of the operating technique required for the safe operation of the particular radiation machine.

(A) The registrant shall ensure and document that each individual has read the operating and safety procedures before operating a radiation machine and reviewed the procedures annually not to exceed 12 months. This documentation shall be maintained in accordance with subsection (k)(2) of this section for inspection by the agency. The documentation shall include the following:

(i) name and signature of individual;

(ii) date individual read the operating and safety procedures; and

(iii) initials of the radiation safety officer.

(B) The operating and safety procedures shall include, but are not limited to, the following procedures as applicable:

(i) ordering x-ray exams in accordance with subsection (b)(1)(A) and (B) of this section;

(ii) providing radiation dose requirements in accordance with paragraph (3)(A) of this subsection;

(iii) instructing workers in accordance with paragraph (3)(D) of this subsection;

(iv) posting notices to workers in accordance with paragraph (4)(B) of this subsection;

(v) posting of a radiation area in accordance with paragraph (4)(C) and (D) of this subsection;

(vi) using a technique chart in accordance with paragraph (5)(A) of this subsection;

(vii) holding of patients or film in accordance with paragraph (11)(A) and (B) of this subsection and subsection (c)(4) of this section;

(viii) following film for processing program or digital imaging acquisition system protocols in accordance with paragraphs (12) - (14) of this subsection;

(ix) notifying and reporting to individuals in accordance with subsection (k)(2) and (3) of this section; and

(x) ensuring security and control of radiation machines in accordance with paragraph (4)(E)(i) of this subsection.

(3) Personnel requirements.

(A) Occupational dose limits.

(i) The registrant shall control the occupational dose to individuals, to the following dose limits.

(I) An annual limit shall be the total effective dose equivalent being equal to 5 rems (0.05 sievert).

(II) The annual limits to the lens of the eye, to the skin of the whole body, and to the skin of any extremities shall be:

(-a-) a lens dose equivalent of 15 rems (0.15 sievert); and

(-b-) a shallow dose equivalent of 50 rems (0.5 sievert) to the skin of the whole body or to the skin of any extremity.

(III) The annual limits for a minor shall be 10% of the annual occupational dose limits specified in subclauses (I) and (II) of this clause.

(IV) If a woman declares her pregnancy, the registrant shall ensure that the dose equivalent to an embryo/fetus during the entire pregnancy, due to occupational exposure of a declared pregnant woman, does not exceed 0.5 rem (5 millisievert). If a woman chooses not to declare pregnancy, the occupational dose limits specified in subclauses (I) and (II) of this clause are applicable to the woman.

(V) The registrant shall make efforts to avoid substantial variation above a uniform monthly exposure rate (air kerma rate) to a declared pregnant woman to satisfy the limit in clause (i) of this subparagraph. The National Council on Radiation Protection and Measurements recommended in NCRP Report No. 116 "Limitation of Exposure to Radiation" (March 31, 1993) that no more than 0.05 rem (0.5 mSv) to the embryo/fetus be received in any one month.

(ii) The assigned deep dose equivalent shall be for the portion of the body receiving the highest exposure. The assigned shallow dose equivalent shall be the dose averaged over the contiguous 10 cm^2 of the skin receiving the highest exposure.

(iii) The deep dose equivalent, lens dose equivalent, and shallow dose equivalent may be assessed from surveys or radiation measurements for demonstrating compliance with the occupational dose limits.

(iv) The registrant shall reduce the dose that an individual may be allowed to receive in the current year by the amount of occupational dose received from radiation machines or radioactive materials while employed by any other person.

(v) The agency may impose additional requirements for controlling occupational exposure to restrict or assess the collective dose.

(B) Dose limits for individual members of the public.

(i) Each registrant shall conduct operations so that:

(I) the total effective dose equivalent to individual members of the public from exposure to radiation from radiation machines does not exceed 0.5 rem (5 millisieverts) in a year, exclusive of the dose contribution from background radiation, exposure of patients to radiation for medical diagnosis or therapy, or to voluntary participation in medical research programs; and

(II) the dose in any unrestricted area from external sources does not exceed 0.002 rem (0.02 millisieverts) in any one hour.

(ii) If the registrant permits members of the public to have access to restricted areas, the limits for members of the public continue to apply to those individuals.

(iii) The agency may impose additional restrictions on radiation levels in unrestricted areas in order to restrict the collective dose.

(C) Occupational doses from other sources of radiation. Individuals who receive occupational doses from sources of radiation other than dental radiation machines may be required to comply with the requirements of §289.231(n) and (q) - (s) of this title.

(D) Instructions to workers. The registrant shall provide instructions to radiation workers before beginning initial work in restricted areas. These instructions shall include the following:

(i) precautions or procedures to minimize exposure;

(ii) the applicable provisions of agency requirements and certificates of registration for the protection of personnel from exposures to radiation occurring in such areas; and

(iii) the radiation worker's responsibility to report promptly to the registrant any condition that may constitute, lead to, or cause a violation of agency requirements or certificate of registration conditions, or unnecessary exposure to radiation.

(4) Facility requirements.

(A) Caution signs. Unless otherwise authorized by the agency, the standard radiation symbol prescribed shall use the colors magenta, purple or black on yellow background. The standard radiation symbol prescribed is the three-bladed design as follows:
Figure: 25 TAC §289.232(j)(4)(A)

(i) the cross-hatched area of the symbol is to be magenta, purple, or black; and

(ii) the background of the symbol is to be yellow.

(B) Posting of notices to workers.

(i) Each registrant shall post current copies of the following documents:

(I) RC Form 232-1, "Notice to Employees," or an equivalent document containing at least the same wording as RC Form 232-1; and
Figure: 25 TAC §289.232(j)(4)(B)(i)(I)

(II) a notice that describes the following documents and states where the documents may be examined:

(-a-) a copy of this section;

(-b-) the certificate of registration and conditions or documents incorporated into the certificate of registration by reference and amendments thereto;

(-c-) the operating procedures applicable to work under the certificate of registration; and

(-d-) any notice of violation, if applicable, involving radiological working conditions, or order issued in accordance with subsections (b) and (l)(3) of this section and documentation of the corrections of any violations.

(ii) Documents, notices, or forms posted in accordance with this subsection shall:

(I) appear in an area visible to all workers to permit individuals engaged in work under the certificate of registration to observe the documents on the way to or from any particular work location to which the document applies;

(II) be conspicuous; and

(III) be replaced if defaced or altered.

(C) Posting requirements. The registrant shall post each radiation area with a conspicuous sign or signs bearing the radiation symbol and the words "CAUTION, RADIATION AREA."

(D) Exceptions to posting requirements. Registrants are exempt from the posting of the radiation area requirements in subparagraph (C) of this paragraph if the operator has continuous surveillance and access control of the radiation area.

(E) Security and control of radiation machines.

(i) The registrant shall establish a protocol to ensure radiation machines are secure from unauthorized removal.

(ii) The registrant shall use devices and administrative procedures to prevent unauthorized use of radiation machines.

(iii) Any person using hand-held dental radiation machines shall ensure proper storage of the unit to include:

(I) securing the unit against theft or unauthorized use; and

(II) storing the unit in locked cabinets, storage rooms or work areas when not under immediate supervision of authorized users.

(5) Radiation machine requirements.

(A) Technique chart.

(i) A technique chart relevant to the particular radiation machine shall be provided or electronically displayed near the control panel and used by all operators.

(ii) Technique and exposure indicators.

(I) The technique factors to be used during an exposure shall be indicated before the exposure begins except:

(-a-) when automatic exposure controls are used, in which case the technique factors that are set before the exposure shall be indicated; or

(-b-) unless prevented by the design of the certified radiation machine.

(II) On radiation machines having fixed technique factors, the requirement of subclause (I) of this clause may be met by permanent markings.

(III) The x-ray control shall provide visual indication of the production of x-rays. In addition, a signal audible to the operator shall indicate that the exposure has terminated.

(IV) The indicated technique factors shall be accurate to within manufacturer's specifications. If these specifications are not available from the manufacturer, the factors shall be accurate to within plus or minus 10% of the indicated setting.

(B) Labeling radiation machines. Each registrant shall ensure that each radiation machine is labeled in a conspicuous manner that cautions individuals that radiation is produced when it is energized. This label shall be affixed in a clearly visible location on the face of the radiation machine.

(C) Mechanical support of tube head. The tube housing assembly shall be adjusted to remain stable during an exposure unless tube housing movement is a designed function of the radiation machine.

(D) Battery charge indicator. On battery-powered x-ray generators, visual means shall be provided on the control panel to indicate whether the battery is in a state of charge adequate for proper operation.

(E) Beam quality. The following requirements apply to beam quality.

(i) Half-value layer.

(I) The half-value layer of the useful beam for a given x-ray tube potential shall not be less than the values shown in the following table. If it is necessary to determine such half-value layer at an x-ray tube potential that is not listed in the table, linear interpolation may be made.
Figure: 25 TAC §289.232(j)(5)(E)(i)(I)

(II) For capacitor energy storage equipment, compliance with the requirements of this subparagraph shall be determined with the maximum quantity of charge per exposure.

(ii) Filtration controls.

(I) For radiation machines that have variable kilovolt peak and variable filtration for the useful beam, a device shall link the kilovolt peak selector with the filters and shall prevent an exposure unless the minimum amount of filtration required by clause (i) of this subparagraph is in the useful beam for the given kilovolt peak that has been selected.

(II) Any other radiation machine having removable filters shall be required to have the minimum amount of filtration as required by clause (i)(I) of this subparagraph permanently located in the useful beam during each exposure.

(F) Multiple tubes. Where two or more radiographic tubes are controlled by one exposure switch, the tube or tubes that have been selected shall be clearly indicated before initiation of the expo-

sure. This indication shall be both on the x-ray control panel and at or near the tube housing assembly that has been selected.

(G) X-ray control. An x-ray control shall be incorporated into each radiation machine such that an exposure can be terminated by the operator at any time, except for exposures of 0.5 second or less. The exposure switch shall be of the continuous pressure type.

(H) Radiation machines needing correction or repair. The correction or repair shall begin within 30 days following the failure and the registrant shall perform or cause to be performed the correction or repair according to a designated plan. Correction or repair shall be completed no longer than 90 days from discovery unless authorized in writing by the agency.

(I) Records of radiation machine corrections or repairs. The registrant shall maintain records of corrections or repairs and any tests, measurements or numerical readings listed in subparagraph (J) of this paragraph in accordance with subsection (k)(2) of this section for inspection by the agency.

(J) Equipment performance evaluations (EPE).

(i) For all dental radiation machines, the registrant shall perform, or cause to be performed, EPE tests for each item specified in clauses (vi) - (xi) of this subparagraph as follows:

(I) within 30 days after initial installation of radiation machines:

(II) within 30 days after reinstallation of a radiation machine; and

(III) within 30 days after repair of a radiation machine component that would affect the radiation output that includes, but is not limited to, the timer, tube, and power supply.

(ii) Frequency of EPE. For x-ray and CT systems, an EPE shall be performed at the frequency listed in the following table. Figure: 25 TAC §289.232(j)(5)(J)(ii)

(iii) Records of the EPE results shall be available for inspection by the agency and shall include the following:

(I) measurements and numerical readings;

(II) indication of pass or fail for each test; and

(III) maintenance by the registrant in accordance with subsection (k)(2) of this section for inspection by the agency.

(iv) Radiation machines needing correction or repair. If a radiation machine requires correction or repair following an EPE, the correction or repair shall begin within 30 days following the failure and the registrant shall perform or cause to be performed the correction or repair according to a designated plan. Correction or repair shall be completed no longer than 90 days from discovery unless authorized in writing by the agency.

(v) Timer.

(I) The accuracy of the timer shall meet the manufacturer's specifications. If the manufacturer's specifications are not obtainable, the timer accuracy shall be plus or minus 10% of the indicated time with testing performed at 0.5 second.

(II) Means shall be provided to terminate the exposure at a preset time interval, a preset product of current and time, a preset number of pulses, or a preset radiation exposure to the image receptor. In addition, it shall not be possible to make an exposure when the timer is set to a "zero" or "off" position if either position is provided.

(vi) Exposure reproducibility. When all technique factors are held constant, including control panel selections associated with automatic exposure control systems, the coefficient of variation of exposure for both manual and automatic exposure control systems shall not exceed 0.05. This requirement applies to clinically used techniques.

(vii) Kilovolt peak. If the registrant possesses documentation of the appropriate manufacturer's kilovolt peak specifications, the radiation machine shall meet those specifications. If the registrant does not possess documentation of the appropriate manufacturer's kilovolt peak specifications, the indicated kilovolt peak shall be accurate to within plus or minus 10% of the indicated settings. For radiation machines with fewer than three fixed kilovolt peak settings, the radiation machine shall be checked at those settings.

(viii) Tube stability. The x-ray tube shall remain physically stable during exposures. In cases where tubes are designed to move during exposure, the registrant shall assure proper and free movement of the radiation machine.

(ix) Collimation. Field limitation shall meet the requirements of paragraphs (9) and (10) of this subsection.

(x) Entrance exposure limits (air kerma limits) for dental facilities. The in-air exposure (entrance air kerma) for an adult bite wing view shall be determined from the exposure technique used by the registrant for the average adult patient. The in-air exposure (entrance air kerma) for intraoral (bite wing) dental radiography shall not exceed the following entrance exposure limits (air kerma limits): Figure: 25 TAC §289.232(j)(5)(J)(x)

(xi) Measurements of the radiation output for a radiation machine. Measurements of the radiation output for a radiation machine shall be performed with a calibrated dosimetry system in accordance with the following.

(I) The dosimetry system calibration shall be traceable to a national standard.

(II) Dosimetry systems shall be calibrated within 24 months from the date of the prior calibration.

(xii) Record of dosimetry system calibration. The registrant shall verify all dosimetry equipment meets the requirements of clause (xi) of this subparagraph.

(6) Dental research.

(A) Any research using radiation machines on humans shall be approved by an Investigational Review Board (IRB) as required by Title 45, CFR, Part 46, and Title 21, CFR, Part 56. The IRB shall include at least one licensed dentist to direct any use of radiation in accordance with this section.

(B) Facilities with radiation machines with investigational device exemptions that are involved in clinical studies shall comply with primary regulations that govern the conduct of clinical studies and that apply to the manufacturers, sponsors, clinical investigators, institutional review boards, and the medical device. These regulations include the following:

(i) 21 CFR, Part 812, Investigational Device Exemptions;

(ii) 21 CFR, Part 50, Protection of Human Subjects;

(iii) 21 CFR, Part 56, Institutional Review Boards;

(iv) 21 CFR, Part 54, Financial Disclosure by Clinical Investigators; and

(v) 21 CFR, Part 820, Subpart C, Design Controls of the Quality System Regulation.

(7) Educational facilities. Facilities conducting training using non-humans are held to all the requirements of this section except for paragraph (5)(J) of this subsection concerning EPE and for paragraphs (12) and (13) of this subsection concerning image processing.

(8) Certified radiation machines for dental facilities. The registrant shall not make, nor cause to be made, any modification of components or installations of components certified in accordance with the United States Food and Drug Administration Title 21, CFR, Part 1020, "Performance Standards for Ionizing Radiation Emitting Products," as amended, in any manner that could cause the installations or the components to fail to meet the requirements of the applicable parts of the standards specified in Title 21, CFR, Part 1020, except where a variance has been granted by the Director, Center for Devices and Radiological Health, United States Food and Drug Administration. A copy of the variance shall be maintained by the registrant in accordance with subsection (k)(2) of this section for inspection by the agency. All modifications of components or installation of components must be approved by the manufacturer.

(9) Additional requirements for dental intraoral radiation machines.

(A) Source-to-skin distance. Radiation machines designed for use with an intraoral image receptor shall be provided with means to limit source-to-skin distance to not less than:

(i) 18 centimeters if operable above 50 kilovolt peak; or

(ii) 10 centimeters if not operable above 50 kilovolt peak.

(B) Field limitation. Radiation machines designed for use with an intraoral image receptor shall be provided with means to limit the x-ray beam such that:

(i) if the minimum source-to-skin distance is 18 centimeters or more, the x-ray field at the minimum source-to-skin distance shall be restricted to a dimension of no more than seven centimeters; and

(ii) if the minimum source-to-skin distance is less than 18 centimeters, the x-ray field at the minimum source-to-skin distance shall be restricted to a dimension of no more than six centimeters.

(10) Additional requirements for dental extraoral radiation machines.

(A) Dental panoramic radiation machines shall be provided with means to restrict the x-ray beam to the following:

(i) the imaging slit in the transverse axis; and

(ii) no more than a total of 0.5 inches larger than the imaging slit in the vertical axis.

(B) All other dental extraoral radiation machines (e.g., cephalometric) shall be provided with means to restrict the x-ray field to the image receptor. The x-ray field shall not exceed the image receptor by more than:

(i) 2.0% of the source-to-image receptor distance for the length or width of the image receptor for rectangular collimation; or

(ii) 2.0% of the source-to-image receptor distance for the diagonal of the image receptor for circular or polygon collimation.

(11) Additional operational controls.

(A) When a patient or image receptor must be held in position during radiography, mechanical supporting or restraining devices shall be used when the exam permits except in individual cases in which the registrant has determined that the holding devices are contraindicated.

(B) The registrant's written operating and safety procedures required by paragraph (2) of this subsection shall include the following:

(i) a list of circumstances in which mechanical holding devices cannot be routinely utilized; and

(ii) a procedure used for selecting an individual to hold or support the patient or image receptor.

(C) The operator position during the exposure shall be such that the operator's exposure is as low as reasonably achievable and the operator is a minimum of six feet from the useful beam or behind a protective barrier. The operator shall maintain verbal, aural, and visual contact with the patient.

(12) Automatic and manual film processing for dental facilities and mobile dental services.

(A) Films shall be developed in accordance with the time-temperature relationships recommended by the film manufacturer. The specified developer temperature for automatic processing and the time-temperature chart for manual processing shall be posted in the processing area. If the registrant determines an alternate time-temperature relationship is more appropriate for a specific facility, that time-temperature relationship shall be documented and posted.

(B) Chemicals shall be replaced according to the chemical manufacturer or supplier's recommendations or at an interval not to exceed three months.

(C) Darkroom light leak tests shall be performed at intervals not to exceed six months.

(D) Lighting in the film processing/loading area shall be maintained with the filter, bulb wattage, and distances recommended by the film manufacturer for that film emulsion or with products that provide an equivalent level of protection against fogging.

(E) Corrections or repairs of the light leaks or other deficiencies in subparagraphs (B) - (D) of this paragraph shall be initiated within 72 hours after discovery and completed no longer than 15 days from detection of the deficiency unless a longer time is authorized by the agency. Records of the corrections or repairs shall include the date and initials of the individual performing these functions and the registrant shall maintain the records in accordance with subsection (k)(2) of this section for inspection by the agency.

(F) Documentation of the items in subparagraphs (B), (C), and (E) of this paragraph shall be maintained at the site where performed and shall include the date and initials of the individual completing these items. These records shall be made and maintained in accordance with subsection (k)(2) of this section for inspection by the agency.

(13) Alternative processing systems. Users of daylight processing systems, laser processors, self-processing film systems, or other alternative processing systems shall follow manufacturer's recommendations for image processing. Documentation that the

registrant is following manufacturer's recommendations shall include the date and initials of the individual completing the document and shall be made and maintained at the authorized use location where performed in accordance with subsection (k)(2) of this section for inspection by the agency.

(14) Digital imaging acquisition systems.

(A) Users of digital imaging acquisition systems shall follow quality assurance/quality control (QA/QC) protocol for digital imaging established by the manufacturer.

(i) The registrant shall include the protocols established in paragraph (2) of this subsection in its operating and safety procedures.

(ii) The registrant shall document the frequency at which the quality assurance/quality control protocol is performed. Documentation shall:

(I) include the date and initials of the individual completing the document and the images acquired; and

(II) be maintained and available at the authorized use location where performed in accordance with subsection (k)(2) of this section for inspection by the agency.

(B) If a protocol cannot be established by the manufacturer, it shall be developed and implemented by the registrant.

(i) The QA/QC protocol, as developed and implemented by the registrant, shall include image quality testing for, but not limited to, spatial resolution, noise, artifacts and contrast by using a commercially purchased testing tool or an inanimate object of at least three varying densities.

(I) Images shall be acquired with each x-ray image receptor at an interval not to exceed three months.

(II) Test images shall be compared to previous test images to assess degradation of image quality.

(III) If a radiation machine or components of the digital imaging acquisition system require correction or repair following a quality test, the correction or repair shall begin within 30 days following the failure and the registrant shall perform or cause to be performed the correction or repair according to a designated plan. Correction or repair shall be completed no longer than 90 days from discovery unless authorized in writing by the agency.

(ii) The registrant shall include the protocols established in paragraph (2) of this subsection in its operating and safety procedures.

(iii) The registrant shall document the frequency at which the quality assurance/quality control protocol is performed. Documentation shall:

(I) include the date and initials of the individual completing the document and the images acquired; and

(II) be maintained and available at the authorized use location where performed in accordance with subsection (k)(2) of this section for inspection by the agency.

(k) Records and reports.

(1) General provisions for records and reports.

(A) Each registrant shall maintain records at each site, including sites authorized by the certificate of registration, conditions, and records sites for mobile services. The records shall include those specified in paragraph (2) of this subsection and shall be maintained at the time interval indicated for inspection by the agency. These records may be maintained in electronic format. These records shall be accessible to radiation machine operators during working hours.

(B) All records required by this section shall be accurate and factual.

(C) Each registrant shall use the SI units gray, sievert, and coulomb per kilogram, or the special units rad, rem, and roentgen, including multiples and subdivisions, and shall clearly indicate the units of all quantities on records required by this section.

(D) The registrant shall make a clear distinction among the quantities entered on the records required by this section, such as, total effective dose equivalent, shallow dose equivalent, lens dose equivalent, and deep dose equivalent.

(E) Each record required by this section shall be legible throughout the specified retention period.

(F) The record shall be the original, a reproduced copy, or a microform, if the authorized personnel authenticate the copy or microform and that the microform is capable of producing a clear copy throughout the required retention period.

(G) The record may also be stored in electronic format with the capability for producing legible, accurate, and complete records during the required retention period.

(H) The registrant shall maintain adequate safeguards against tampering with and loss of records.

(I) Copies of records required in subsections (i)(5)(I) and (J), (j)(5)(J), and (j)(12)(F) of this section and by certificate of registration condition that are relevant to operations at an additional authorized use location shall be maintained at that location in addition to the main site specified on a certificate of registration in accordance with subsection (k)(2) of this section.

(J) Subject to the limitations provided in the Texas Public Information Act, Government Code, Chapter 552, all information and data collected, assembled, or maintained by the agency are public records open to inspection and copying during regular office hours.

(K) Any person who submits written information or data to the agency and requests that the information be considered confidential, privileged, or otherwise not available to the public under the Texas Public Information Act, shall justify such request in writing, including statutes and cases where applicable, addressed to the agency.

(i) Documents containing information that is claimed to fall within an exception to the Texas Public Information Act shall be marked to indicate that fact. Markings shall be placed on the document on origination or submission.

(I) The words "NOT AN OPEN RECORD" shall be placed conspicuously at the top and bottom of each page containing information claimed to fall within one of the exceptions.

(II) The following wording shall be placed at the bottom of the front cover and title page, or first page of text if there is no front cover or title page:
Figure: 25 TAC §289.232(k)(1)(K)(i)(II)

(ii) The agency requests, whenever possible, that all information submitted under the claim of an exception to the Texas Public Information Act be extracted from the main body of the application and submitted as a separate annex or appendix to the application.

(iii) Failure to comply with any of the procedures that are described in clauses (i) and (ii) of this subparagraph may re-

sult in all information in the agency file being disclosed upon an open records request.

(L) The agency will determine whether information falls within one of the exceptions to the Texas Public Information Act. The agency will determine whether there has been a previous determination that the information falls within one of the exceptions to the Texas Public Information Act. If there has been no previous determination and the agency believes that the information falls within one of the exceptions, an opinion of the Attorney General will be requested. If the agency agrees in writing to the request, the information shall not be open for public inspection unless the Attorney General's office subsequently determines that it is not an exception.

(M) Requests for information.

(i) All requests for open records information shall be in writing and refer to documents currently in possession of the agency.

(ii) The agency will determine whether the information may be released or whether it falls within an exception to the Texas Public Information Act.

(I) The agency may take a reasonable period to determine whether information falls within one of the exceptions to the Texas Public Information Act.

(II) If the information is determined to be public, it will be presented for inspection and copies of documents will be furnished within a reasonable period. A fee will be charged to recover agency costs for copies.

(iii) Original copies of public records may not be removed from the agency. Under no circumstances shall material be removed from existing records.

(2) Records requirements.

(A) Each registrant shall maintain the following records at each site, including authorized records sites for mobile services, at the time intervals specified and make available to the agency for inspection. The records may be maintained in electronic format.
Figure: 25 TAC §289.232(k)(2)(A)

(B) For radiation machines authorized for mobile service, copies of the records specified in the table in subparagraph (A)(iii)-(v) of this paragraph shall be maintained with the radiation machine in accordance with subparagraph (A) of this paragraph for inspection by the agency. If on-board processors are utilized, image processing records shall also be made on board in accordance with subsection (j)(12), (13), and (14) of this section and maintained in accordance with subparagraph (A) of this paragraph for inspection by the agency.

(C) For authorized records sites for mobile services, copies of the records specified in subparagraph (A)(ii) and (vi)-(xii) of this paragraph shall be maintained in accordance with subparagraph (A) of this paragraph for inspection by the agency.

(3) Reports.

(A) Reports of stolen, lost, or missing radiation machines.

(i) Each registrant shall report to the agency by telephone a stolen, lost, or missing radiation machine immediately after its occurrence becomes known to the registrant.

(ii) Within 30 days after making the telephone report, each registrant required to make a report according to clause (i) of this subparagraph shall make a written report to the agency that includes the following information:

(I) a description of the radiation machine involved, including the manufacturer name, model and serial number;

(II) a description of the circumstances under which the loss or theft occurred;

(III) actions that have been taken, or will be taken, to recover the radiation machine; and

(IV) procedures or measures that have been, or will be, adopted to ensure against a recurrence of the loss or theft of radiation machines.

(iii) Subsequent to filing the written report, the registrant shall also report additional information pertaining to the loss or theft within 30 days after the registrant learns of such information.

(iv) The registrant shall prepare any report filed with the agency in accordance with this subsection so that names of individuals who may have received exposure to radiation are stated in a separate and detachable portion of the report.

(B) Reports of incidents.

(i) Notwithstanding other requirements for notification, each registrant shall immediately report each event involving a radiation machine possessed by the registrant that may have caused or threatens to cause an individual, except radiation administered for healing arts purposes, to receive:

(I) a total effective dose equivalent of 25 rems (0.25 sievert) or more;

(II) a lens dose equivalent of 75 rems (0.75 sievert) or more; or

(III) a shallow dose equivalent to the skin of the whole body or to the skin of any extremities of 250 rads (2.5 grays) or more.

(ii) Within 24 hours of discovery of the event, each registrant shall report to the agency each event involving loss of control of a radiation machine possessed by the registrant that may have caused, or threatens to cause an individual to receive, in a period of 24 hours:

(I) a total effective dose equivalent exceeding 5 rems (0.05 sievert);

(II) a lens dose equivalent exceeding 15 rems (0.15 sievert); or

(III) a shallow dose equivalent to the skin of the whole body or to the skin of any extremities exceeding 50 rems (0.5 sievert).

(iii) Registrants shall make the initial notification reports required by clauses (i) and (ii) of this subparagraph by telephone to the agency and shall confirm the initial notification report within 24 hours by facsimile or other electronic media to the agency.

(iv) The registrant shall prepare each report filed with the agency in accordance with this section so that names of individuals who have received exposure to sources of radiation are stated in a separate and detachable portion of the report.

(C) Reports of exposures and radiation levels exceeding the limits.

(i) In addition to the notification required by subparagraph (B) of this paragraph, each registrant shall submit a written report within 30 days after learning of any of the following occurrences:

(I) incidents for which notification are required by subparagraph (B) of this paragraph;

(II) doses in excess of any of the following:

(-a-) the occupational dose limits for adults in subsection (j)(3)(A)(i) of this section;

(-b-) the occupational dose limits for a minor in subsection (j)(3)(A)(i)(III) of this section;

(-c-) the limits for an embryo/fetus of a declared pregnant woman in subsection (j)(3)(A)(i)(IV) and (V) of this section;

(-d-) the limits for an individual member of the public in subsection (j)(3)(B) of this section; or

(-e-) any applicable limit in the certificate of registration;

(III) levels of radiation in:

(-a-) a restricted area in excess of applicable limits in the certificate of registration; or

(-b-) an unrestricted area in excess of 10 times the applicable limit set forth in this section or in the certificate of registration conditions, whether or not involving exposure of any individual in excess of the limits in subsection (j)(3)(B) of this section.

(ii) Each report required by clause (i) of this subparagraph shall describe the extent of exposure of individuals to radiation, including, as appropriate:

(I) estimates of each individual's dose;

(II) the levels of radiation involved;

(III) the cause of the elevated exposures, dose rates; and

(IV) corrective steps taken or planned to ensure against a recurrence, including the schedule for achieving conformance with applicable limits, and associated registration conditions.

(iii) Each report filed in accordance with clause (i) of this subparagraph shall include, for each individual exposed, the name, a unique identification number, and date of birth. With respect to the limit for the embryo/fetus in subsection (j)(3)(A)(i)(IV) and (V) of this section, the identifiers should be those of the declared pregnant woman. The report shall be prepared so that this information is stated in a separate and detachable portion of the report.

(D) Reports to individuals of exposures.

(i) If applicable, radiation exposure data for an individual shall be reported to the individual as specified in this paragraph. The information reported shall include data and results obtained in accordance with requirements of this section, orders, certificate of registration conditions, as shown in records made and maintained by the registrant in accordance with this subsection. Each notification and report shall:

(I) be in writing;

(II) include appropriate identifying data such as the name of the registrant, the name of the individual, and the individual's identification number;

(III) include the individual's exposure information; and

(IV) contain the following statement: "This report is furnished to you under the provisions of the Texas Regulations for Control of Radiation, 25 Texas Administrative Code §289.232(j)(3)(A) - (C). You should preserve this report for further reference."

(ii) If applicable, each registrant shall provide an annual written report to advise each worker of the worker's estimated dose, received in that monitoring year, as shown in records made and maintained by the registrant in accordance with subparagraph (C) of this paragraph if:

(I) the individual's occupational dose exceeds 100 mrem (1 mSv) total effective dose equivalent or 100 mrem (1 mSv) to any individual organ or tissue; or

(II) the individual requests his or her annual dose report in writing.

(iii) When a registrant is required in accordance with subparagraphs (B) and (C) of this paragraph to report to the agency any exposure of an identified occupationally exposed individual, or an identified member of the public, to radiation, the registrant shall also notify the individual and provide the individual with a copy of the report submitted to the agency, including the information required by clause (i) of this subparagraph. Such reports shall be transmitted no later than the transmittal to the agency.

(l) Compliance and hearing procedures.

(1) Inspections. The agency may enter public or private property at reasonable times to determine whether, in a matter under the agency's jurisdiction, there is compliance with the Act, the requirements of this section, certificate of registration conditions, and orders issued by the agency.

(A) Each registrant shall perform, upon instructions from the agency, or shall permit the agency to perform such reasonable surveys, as the agency deems appropriate or necessary, including, but not limited to, surveys of:

(i) radiation machines;

(ii) facilities where radiation machines are used; and

(iii) other radiation machines and devices used in connection with utilization of radiation machines.

(B) The routine inspection interval for dental facilities is four years. On-site inspections and remote inspections may be alternated as determined by the agency. The inspection interval specified is based upon the average number of health-related violations per inspection, as determined from compliance history data. Registrant's having certificates of registration authorizing multiple radiation machine use categories will be inspected on-site at the most frequent interval specified for the radiation machine uses authorized.

(i) Notwithstanding the inspection interval specified in this subparagraph, the agency may inspect registrants more frequently due to:

(I) the persistence or severity of violations found during an inspection;

(II) investigation of an incident or complaint concerning the facility;

(III) a request for an inspection by a worker in accordance with paragraph (2) of this subsection;

(IV) any change in a facility or radiation machine that might cause a significant increase in radiation output or hazard; or

(V) a mutual agreement between the agency and registrant.

(ii) The agency will conduct inspections of dental radiation machines in a manner designed to cause as little disruption of a dental practice as is practicable.

(C) On-site Inspections.

(i) Each registrant shall afford to the agency at all reasonable times opportunity to inspect materials, radiation machines, activities, facilities, premises, and records in accordance with this section.

(ii) During an inspection, agency inspectors may obtain and retain paper or electronic copies of requested documentation in accordance with this section.

(iii) Each registrant shall make available to the agency for inspection records made and maintained in accordance with this section.

(iv) Agency inspectors may consult privately with workers concerning matters of occupational radiation protection and other matters related to applicable provisions of agency regulations and certificates of registration to the extent the inspectors deem necessary for the conduct of an inspection.

(v) An employee who routinely is engaged in work under control of the registrant, operating the radiation machines for healing arts purposes, shall be made available to operate the radiation machines at the time of the inspection and engage in the inspection process.

(vi) Notwithstanding the other provisions of this section, agency inspectors are authorized to refuse to permit accompaniment by any individual who interferes, delays, or causes to be delayed an inspection.

(D) For remote inspection of dental radiation machines, each registrant shall:

(i) respond to a request from the agency for a remote inspection;

(ii) complete the remote inspection forms in accordance with the instructions included with the forms; and

(iii) return to the agency the completed remote inspection forms, including documentation of the most recent EPE performed in accordance with subsection (j)(5)(J) of this section and an inventory in accordance with subsection (i)(5)(I) of this section by the deadline indicated on the forms.

(E) During the course of an inspection, any worker may privately inform the inspectors, either verbally or in writing, any past or present condition which that individual has reason to believe may have contributed to or caused any violation of the Act, the requirements in this section, certificate of registration conditions, or any unnecessary exposure of an individual to radiation from any radiation machine source of radiation under the registrant's control. Any such notice in writing shall comply with the requirements of paragraph (2) of this subsection.

(F) The provisions of subparagraph (E) of this paragraph shall not be interpreted as authorization to disregard instructions in accordance with subsection (j)(3)(D) of this section.

(2) Complaints. Any worker or representative of a worker who believes that a violation of the Act, the requirements of this section, or certificate of registration conditions exists or has occurred in work under a certificate of registration with regard to radiological working conditions in which the worker is engaged, may request an inspection by giving notice of the alleged violation to the agency. Any such notice shall be in writing, shall set forth the specific grounds for the notice, and the worker or representative of the worker shall sign the notice. A copy shall be provided to the registrant by the agency no later than at the time of inspection except that, upon the request of the worker giving such notice, the worker's name and the name of individual referred to therein shall not appear in such copy or on any record published, released, or made available by the agency, except for good cause shown.

(A) If, upon receipt of such notice, the agency determines that the request meets the requirements set forth in this paragraph, and that there are reasonable grounds to believe that the alleged violation exists or has occurred, an inspection shall be made as soon as practicable to determine if such alleged violation exists or has occurred. Inspections in accordance with this section need not be limited to matters referred in the request.

(B) No registrant, contractor or subcontractor of a registrant shall discharge or in any manner discriminate against any worker because of the following:

(i) such worker has filed any request or instituted or caused to be instituted any proceeding under this section;

(ii) such worker has testified or is about to testify in any such proceeding; or

(iii) because of the exercise by such worker on behalf of that individual or others of any option afforded by this section.

(C) Inspections not warranted.

(i) If the agency determines, with respect to a request under subparagraphs (A) and (B) of this paragraph, that an inspection is not warranted because there are no reasonable grounds to believe that a violation exists or has occurred, the agency shall notify the requestor in writing of such determination. The requestor may obtain review of such determination in accordance with the provisions of the Act and the Government Code, Chapters 2001 and 2002.

(ii) If the agency determines that an inspection is not warranted because the requirements of this paragraph have not been met, the agency shall notify the requestor in writing of such determination. Such determination shall be without prejudice to the filing of a new request meeting the requirements of this paragraph.

(D) Agency inspectors are required to have special training in the design and uses of medical x-ray equipment. Inspector training requirements and standards will be detailed in the Radiation Control Program policies and procedures manual.

(3) Hearing and enforcement procedures.

(A) Violations.

(i) A court injunction or agency order may be issued prohibiting any violation of any provision of the Act or any requirement of this section or order issued thereunder.

(ii) Any person who violates any provision of the Act or any requirement of this section or order issued thereunder may be subject to civil or administrative penalties.

(iii) Such person may also be guilty of a misdemeanor and upon conviction, may be punished by fine or imprisonment or both, as provided by law.

(B) Denial of an application for a certificate of registration.

(i) When the agency contemplates denial of an application for certificate of registration as outlined in subparagraph (A)(i) of this paragraph, the registrant shall be afforded the opportunity for a hearing. Notice of the denial shall be delivered to the registrant by mail, addressed to the last known address of the registrant.

(ii) Any applicant or registrant against whom the agency contemplates denial of an application may request a hearing by submitting a written request to the director within 30 days after service of the notice or date of mailing.

(I) The written request for a hearing shall contain the following:

(-a-) statement requesting a hearing; and

(-b-) name and address of the applicant or registrant.

(II) Failure to submit a written request for a hearing within 30 days after notice is sent will render the agency action final.

(C) Compliance procedures for registrants and other persons.

(i) A registrant or other person who commits a violation will be issued a notice of violation. The person receiving the notice shall provide the agency with a written statement and supporting documentation by the date stated in the notice describing the following:

(I) steps taken by the person and the results achieved;

(II) corrective steps to be taken to prevent recurrence; and

(III) the date when full compliance was or is expected to be achieved. The agency may require responses to notices of violation to be under oath.

(ii) The terms and conditions of all certificates of registration shall be subject to amendment or modification. A certificate of registration may be modified, suspended, or revoked by reason of amendments to the Act, or for violation of the Act, the requirements of this section, a condition of the certificate of registration, or an order of the agency.

(iii) Any certificate of registration may be modified, suspended, or revoked in whole or in part, for any of the following:

(I) any material false statement in the application or any statement of fact required in accordance with provisions of the Act;

(II) conditions revealed by such application or statement of fact or any report, record, or inspection, or other means that would warrant the agency to refuse to grant a certificate of registration on an original application;

(III) violation of, or failure to observe any of the applicable terms and conditions of the Act, this section, or of the certificate of registration, or order of the agency; or

(IV) existing conditions that constitute a substantial threat to the public health or safety or the environment.

(iv) If another state or federal entity takes an action such as modification, revocation, or suspension of the certificate of registration, the agency may take a similar action against the registrant.

(v) When the agency determines that the action provided for in clause (viii) of this subparagraph or subparagraph (D) of this paragraph is not to be taken immediately, the agency may offer the registrant an opportunity to attend an informal conference to discuss the following with the agency:

(I) methods and schedules for correcting the violations; or

(II) methods and schedules for showing compliance with applicable provisions of the Act, the requirements of this section, certificate of registration conditions, or any orders of the agency.

(vi) Notice of any informal conference shall be delivered by personal service, or certified mail, addressed to the last known address. An informal conference is not a prerequisite for the action to be taken in accordance with clause (viii) of this subparagraph or subparagraph (D) of this paragraph.

(vii) Except in cases in which the occupational and public health or safety requires otherwise, no certificate of registration shall be suspended or revoked unless, before the institution of proceedings therefore, facts or conduct that may warrant such action shall have been called to the attention of the registrant in writing, and the registrant shall have been afforded an opportunity to demonstrate compliance with all lawful requirements.

(viii) When the agency contemplates modification, suspension, or revocation of the certificate of registration, the registrant shall be afforded the opportunity for a hearing. Notice of the contemplated action, along with a complaint, shall be given to the registrant by personal service or certified mail, addressed to the last known address.

(ix) Any applicant or registrant against whom the agency contemplates an action described in clause (viii) of this subparagraph may request a hearing by submitting a written request to the director within 30 days after service of the notice.

(I) The written request for a hearing shall contain the following:

(-a-) statement requesting a hearing;

(-b-) name, address, and identification number of the registrant against whom the action is being taken.

(II) Failure to submit a written request for a hearing within 30 days after notice is sent will render the agency action final.

(D) Assessment of administrative penalties.

(i) When the agency determines that monetary penalties are appropriate, proposals for assessment of and hearings on administrative penalties shall be made in accordance with Health and Safety Code, §401.384; Title 1, Texas Administrative Code, Chapter 155; and applicable sections of the Formal Hearing Procedures, §§1.21, 1.23, 1.25, and 1.27 of this title.

(ii) Assessment of administrative penalties shall be based on the following criteria:

(I) the seriousness of the violations;

(II) previous compliance history;

(III) the amount necessary to deter future violations;

(IV) efforts to correct the violations; and

(V) any other mitigating or enhancing factors.

(iii) Application of administrative penalties. The agency may impose differing levels of penalties for different severity level violations and different classes of users as follows.

(I) Administrative penalties may be imposed for severity level I and II violations. Administrative penalties may be imposed for severity level III, IV, and V violations when the violations are combined with those of higher severity levels or for repeated violations.

(II) The following Tables A and B show the base administrative penalties.
Figure: 25 TAC §289.232(l)(3)(D)(iii)(II)

(III) Adjustments to the percentages of base amounts in Table B may be made for the presence or absence of the following factors:

(-a-) prompt identification and reporting;
(-b-) corrective action to prevent recurrence;
(-c-) compliance history;
(-d-) prior notice of similar event;
(-e-) multiple occurrences; and
(-f-) negligence that resulted in or increased adverse effects.

(IV) The penalty for each violation may be in an amount not to exceed $10,000 a day for a person who violates the Act or requirements of this section, order, or certificate of registration issued in accordance with the Act. Each day a violation continues may be considered a separate violation for purposes of penalty assessment.

(iv) The agency may conduct settlement negotiations.

(E) Severity levels of violations for registrants or other persons.

(i) Violations for registrants or other persons shall be categorized by one of the following severity levels.

(I) Severity level I are violations that are most significant and may have a significant negative impact on occupational or public health and safety or on the environment.

(II) Severity level II are violations that are very significant and may have a negative impact on occupational or public health and safety or on the environment.

(III) Severity level III are violations that are significant and which, if not corrected, could threaten occupational or public health and safety or the environment.

(IV) Severity level IV are violations that are of more than minor significance, but if left uncorrected, could lead to more serious circumstances.

(V) Severity level V are violations that are of minor safety or environmental significance.

(ii) Criteria to elevate or reduce severity levels.

(I) Severity levels may be elevated to a higher severity level for the following reasons:

(-a-) more than one violation resulted from the same underlying cause;
(-b-) a violation contributed to or was the consequence of the underlying cause, such as a management breakdown or breakdown in the control of registered activities;
(-c-) a violation occurred multiple times between inspections;
(-d-) a violation was willful or grossly negligent;
(-e-) compliance history; or
(-f-) other mitigating factors.

(II) Severity levels may be reduced to a lower level for the following reasons:

(-a-) the registrant identified and corrected the violation before the agency inspection;
(-b-) the registrant's actions corrected the violation and prevented recurrence; or
(-c-) other mitigating factors.

(iii) Examples of severity levels. Examples of severity levels are available upon request to the agency.

(F) Impoundment of radiation machines. Radiation machines shall be subject to impounding in accordance with Health and Safety Code, §401.068 and this paragraph.

(i) In the event of an emergency, the agency shall have the authority to impound or order the impounding of radiation machines possessed by any person not equipped to observe or failing to observe the provisions of the Act, or any requirements of this section, certificate of registration conditions, or orders issued by the agency. The agency shall submit notice of the action to be published in the *Texas Register* no later than 30 days following the end of the month in which the action was taken.

(ii) At the agency's discretion, the impounded radiation machines may be disposed of by:

(I) returning the radiation machine to a properly registered owner, upon proof of ownership, who did not cause the emergency;

(II) releasing the radiation machine as evidence to police or courts;

(III) returning the radiation machine to a registrant after the emergency is over and settlement of any compliance action; or

(IV) selling, destroying or other disposition within the agency's discretion.

(iii) If agency action is necessary to protect the public health and safety, no prior notice need be given the owner or possessor. If agency action is not necessary to protect the public health and safety, the agency will give written notice to the owner or the possessor of the impounded radiation machine of the intention to dispose of the radiation machine. Notice shall be the same as provided in subparagraph (C)(viii) of this paragraph. The owner or possessor shall have 30 days from the date of personal service or mailing to request a hearing under Title 1, Texas Administrative Code, Chapter 155, and the Formal Hearing Procedures, §§1.21, 1.23, 1.25, and 1.27 of this title, and in accordance with subparagraph (C)(ix) of this paragraph, concerning the intention of the agency. If no hearing is requested within that period, the agency may take the contemplated action, and such action is final.

(iv) Upon agency disposition of a radiation machine, the agency may notify the owner or possessor of any expense the agency may have incurred during the impoundment or disposition and request reimbursement. If the amount is not paid within 60 days from the date of notice, the agency may request the Attorney General to file suit against the owner or possessor for the amount requested.

(v) If the agency determines from the facts available that an impounded radiation machine is abandoned, with no reasonable evidence showing its owner or possessor, the agency may make such disposition of the radiation machine as it sees fit.

(G) Emergency orders.

(i) When an emergency exists requiring immediate action to protect the public health or safety or the environment, the agency may, without notice or hearing, issue an order citing the existence of such emergency and require that certain actions be taken as the agency directs to meet the emergency. No later than 30 days following the end of the month in which the action was taken, the agency shall submit notice of the action for publication in the *Texas Register.* The

action taken will remain in full force and effect unless and until modified by subsequent action of the agency.

(ii) An emergency order takes effect immediately upon service.

(iii) Any person receiving an emergency order shall comply immediately.

(iv) The person receiving the order shall be afforded the opportunity for a hearing on an emergency order. Notice of the action, along with a complaint, shall be given to the person by personal service or certified mail, addressed to the last known address. A hearing shall be held on an emergency order if the person receiving the order submits a written request to the director within 30 days after the date of the order.

(I) The hearing shall be held not less than 10 days nor more than 20 days after receipt of the written application for hearing.

(II) At the conclusion of the hearing and after the proposal for decision is made as provided in the Texas Administrative Procedure Act, Texas Government Code, Chapter 2001, the commissioner shall take one of the following actions:

(-a-) determine that no further action is warranted;

(-b-) amend the certificate of registration;

(-c-) revoke or suspend the certificate of registration;

(-d-) rescind the emergency order; or

(-e-) issue such other order as is appropriate.

(III) The application and hearing shall not delay compliance with the emergency order.

(H) Miscellaneous provisions.

(i) Computation of time. A time established by the requirements of this section shall begin on the first day after the event that invokes the time. When the last day of the period falls on a Saturday, Sunday, or state or federal holiday, the time shall end on the next day that is not a Saturday, Sunday, or state or federal holiday. The time shall expire at 5:00 p.m. of the last day of the computed time.

(ii) Hearing location. Hearings will be held at the offices of the State Office of Administrative Hearings in Austin unless the administrative law judge specifies another location.

(iii) Non-party witness and mileage fees.

(I) A witness or deponent who is not a party (or an employee, agent, or representative of a party) and who is subpoenaed or otherwise compelled to attend an agency hearing or a proceeding to give a deposition, or to produce books, records, papers, accounts, documents, or other objects necessary and proper for the purposes of the hearing or proceeding may receive reimbursement for transportation and other costs at rates established by the current Appropriations Act for state employees.

(II) The person requesting the attendance of the witness or deponent shall deposit with the agency the funds estimated to accrue in accordance with subclause (I) of this clause when filing a motion for the issuance of a subpoena or a commission to take a deposition.

(iv) Service. A return of service by the person who performed personal service, postal return receipt, or proof of mailing to the last known address shall be conclusive evidence of service.

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 December 21, 2018.

TRD-201805566
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General Counsel
Department of State Health Services
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 834-6656

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER M. FILING REQUIREMENTS

The Texas Department of Insurance proposes amendments to 28 TAC Chapter 5, Subchapter M, Division 4, §5.9310; Division 6, §§5.9330 - 5.9335; Division 7, §§5.9340 - 5.9342; Division 8, §5.9351 - §5.9352; Division 9, §5.9355 - §5.9357; Division 10, §5.9360 and §5.9361; Division 11, §§5.9370 - 5.9374 and §5.9376; and new §5.9311 and §5.9312 in Division 4. TDI also proposes to repeal and replace the current Division 5, §§5.9320 - 5.9323 with new Division 5, §§5.9320 - 5.9328. These amendments, new sections, and repeal relate to requirements for property and casualty filings for forms, rates, rules, underwriting guidelines, credit scoring models, and certificates of insurance. The proposed amendments, new sections, and repeal implement Senate Bill 978, 84th Legislature, Regular Session (2015); SB 1554, 84th Legislature, Regular Session (2015); and House Bill 1298, 85th Legislature, Regular Session (2017). These bills revised Insurance Code Chapters 2053, 2251, and 2301. The amendments and repeal also reorganize and update the rules to make them clearer and more user-friendly, and they promote more efficient processing of filings by making the use of the System for Electronic Rate and Form Filing (SERFF) mandatory.

EXPLANATION. The following section-by-section summary provides detailed descriptions of the proposed changes to Divisions 4 through 11 of 28 TAC Chapter 5, which are commonly referred to as the "Filings Made Easy rules."

Division 4. Transmittal Information and General Filing Requirements for Property and Casualty Form, Rate and Rule, Underwriting Guideline, and Credit Scoring Model Filings.

Section 5.9310. Property and Casualty Transmittal Information and General Filing Requirements. The amendments to §5.9310 alphabetize the definitions, revise the definitions of "interline filing" and "multi-peril insurance," add definitions for the terms "NAIC" and "SERFF," and make minor editorial revisions to the definition of a "reference filing."

The definition of multi-peril insurance in §5.9310(b)(3) incorporates the new definition of "commercial property insurance" in HB 1298. HB 1298 amended Insurance Code §2251.002 and

§2301.002 by defining "commercial property insurance" as "insurance coverage against loss caused by or resulting from loss, damage, or destruction of real or personal property provided through a commercial property insurance policy. The term includes any combination of commercial fire or allied lines; commercial inland marine insurance; commercial crime coverage; boiler and machinery insurance other than explosion; glass insurance provided as part of other coverage; and, as authorized by Commissioner rule, insurance covering other perils or providing other coverages or other lines of first party property insurance."

The updated definition of an "interline filing" better describes the forms that can be filed together and used for more than one line of insurance.

The amendments also clarify that the company name provided by a filer must be the name used for financial reporting to NAIC. New language requires filers to include the TDI file number for the previously approved policy that a proposed form will be attached to. A new subsection requires third-party filers to submit a letter of authorization.

Current language in §5.9310 about information marked "copyright" or confidential information is deleted from the section, and similar language is proposed in new §5.9311.

Amendments to §5.9310 also update the instructions on how insurers may submit filings. The proposed rule requires that filings under Divisions 5, 6, 7, 8, and 9 must be submitted through SERFF.

SERFF is TDI's system of record for all filings subject to the Filings Made Easy rules. Currently, when filers deliver or mail paper filings to TDI, staff must organize, scan, and upload the filings into SERFF. In addition, when filers do not use SERFF, TDI must communicate with those filers through email, fax, mail, or by phone. There have been times when filers did not receive these communications from TDI, or vice versa, because of incorrect contact information. Using SERFF eliminates these communication problems and improves efficiency.

TDI has amended rule text regarding public disclosure of contact information so that it conforms to the mandatory use of SERFF. This text has been deleted from Divisions 5, 6, 8, and 9 and similar text has been proposed in §5.9310(g), since that section will apply to all filings for property and casualty forms, rates and rules, underwriting guidelines, and credit scoring model filings.

Section 5.9311. Copyright, Public Inspection, and Confidential Filings. Proposed new §5.9311 organizes the rule to put similar items together. The proposed amendments delete text about copyright and public inspection in current §5.9310(e) and include similar provisions in proposed §5.9311(a) and (b). The proposed text in §5.9311 does not include the reference to Insurance Code Chapter 2251 that is in the current §5.9310(e), as §5.9311(a) applies generally to all filings. Section 5.9311(b) provides information on public inspection of filings under Insurance Code Chapters 2053, 2251, and 2301 and restates the statutory language about public inspection in those chapters.

New §5.9311(c) addresses filings marked confidential. A function in SERFF allows filers to mark entire filings as confidential. When filers do this, the public does not know that a filing was made, but the public has a right to know that a filing exists. The fact that a filing was made is not confidential. TDI will reject filings that are marked wholly confidential and filers will need to resubmit their filings correctly.

Section 5.9312. Personally Identifiable Information. Proposed new §5.9312 states that TDI may reject filings that include personally identifiable information. This kind of information must remain confidential and should not be included in filings.

New Division 5. Requirements for Property and Casualty Policy Form and Endorsement Filings.

Section 5.9320. Purpose and Definitions. Proposed new §5.9320 provides the purpose and definitions for Division 5, which is similar to §5.9320(a) and (b) in the current rule.

Section 5.9321. General Filing Requirements. Proposed new §5.9321 provides the general filing requirements for policy forms and endorsements. Many of these requirements are the same as in current §5.9320(c) and (h). The new information required in this proposed section includes the requirements that filings contain the form number and edition date for each proposed form, the TDI file number for the previously approved policy that a proposed form will attach to, and a form usage table. TDI staff often request this information from filers. Requiring this information with the filing will help reduce the time for staff to review the filing. Section 5.9321 requires that filers provide a separate marked up copy of each amended policy form and endorsement. Many filers already do this; making it a requirement will also help expedite staff's review of filings.

Proposed §5.9321 also requires filings to include the readability score from the Flesch Reading Ease Test for each filed form or endorsement for personal automobile and residential property. This requirement is in Insurance Code §2301.053 and is included in Commissioner's Order Number 92-0573. It is included in the new rule for efficiency.

Section 5.9322. Additional Information. Proposed new §5.9322 includes filing requirements similar to those in current §5.9320(c)(2), along with new language clarifying that TDI may request related forms or information to support the filing. Filers already provide supporting information at TDI's request.

Section 5.9323. Requirements for Reference Filings. Proposed new §5.9323 is similar to §5.9320(e) in the current rule. The new section adds a requirement for reference filings for personal automobile, residential property, and personal multi-peril insurance by requiring the filer to include a list of each form and endorsement that the insurer will use from each referenced filing and a form usage table. Filers are accustomed to providing this information already.

As proposed, §5.9323 also adds clarifying language that if a filer amends a form or endorsement that was previously approved for another insurer or advisory organization, then it is not a reference filing.

Section 5.9324. Incomplete Filings. Proposed new §5.9324 is similar to §5.9320(g) in the current rule. The only differences are for nonsubstantive editorial and formatting to conform the section to the agency's current style and to provide better clarity.

Section 5.9325. Request for Deemer Period Waiver. The text in proposed new §5.9325 replaces §5.9321 of the current rule. The only differences are for nonsubstantive formatting to conform the section to the agency's current style.

Section 5.9326. Insurers Providing Coverage through a Purchasing Group. The text in new §5.9326 duplicates §5.9322(a) of the current rule.

Section 5.9327. Residential Property Declarations Pages Forms. This proposed new §5.9327 is similar to §5.9323 under

the current rule. The proposal includes updated references and nonsubstantive differences in formatting to conform the section to the agency's current style and to provide better clarity.

Section 5.9328. Insurers Writing Commercial Group Property Insurance. Proposed new §5.9328 replaces §5.9322(b). In the current rule, this subsection was inadvertently placed in the rule about purchasing groups.

Division 6. Requirements for Rate and Rule Filings.

Section 5.9330. Purpose. Under the current Filings Made Easy rules, manual rules are filed under Division 5 in §5.9320(d). The proposed rule deletes the language in Division 5 and, as amended, §5.9330 requires filers to file rules under Division 6. Amended §5.9330 also includes language that mirrors Division 5 by requiring all insurer and advisory organization filings to comply with the filing requirements of Division 6 and any other applicable rules adopted by the Commissioner.

Section 5.9331. Definitions. Amended §5.9331 makes minor grammatical corrections, updates a reference to the Insurance Code, and adds clarifying language to the definition of "short track filing."

Section 5.9332. Categories of Supporting Information. Amended §5.9332 deletes the opening language, which is not necessary to describe the section since the section title is clear. The amendments also update the description for several categories of supporting information, make minor grammatical corrections, and make nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

In the category of "actuarial support" in §5.9332(3), the term "data" is replaced with "loss experience." Data is a generic term used to describe many things. Insurance Code §2251.052(a) states that in setting rates, an insurer must use loss experience. An insurer can also use other information. The category of "actuarial support" was revised to remind filers that the actuarial support must demonstrate why the proposed rates are not excessive, inadequate, or unfairly discriminatory.

The category titled "SERFF rate data" in §5.9332(4) is amended to delete language that was relevant to filers that did not use SERFF. Under the proposed rules, SERFF is mandatory, so this language is not needed.

The category titled "policyholder impact information" in §5.9332(5) is amended to clarify that insurers must use information reflecting the changes for all policyholders to determine the policyholder impact. TDI became aware that some filers were only using a subset of their policyholders to compute this information, which could lead to inaccurate estimates of the expected impact to policyholders. In addition, the description for this category eliminates references to specific lines of insurance. Under §5.9334, policyholder impact information is required in filings for owner-occupied homeowner and personal automobile insurance. This requirement does not change with this proposed rule. If this information is necessary for other lines of insurance, TDI can ask for it in a request for information under §5.9335.

A similar change is proposed to the category titled "average rate change by county" in §5.9332(6). The description deletes the term "homeowners" and adds that the average rate change by county may be provided separately by coverage. Similar to policyholder impact information, filers must submit the average rate change by county in filings for owner-occupied homeowners insurance, as required by §5.9334. However, TDI could ask for this category of supporting information for other lines of insurance in a request for information under §5.9335.

The category titled "rate change information" in §5.9332(7) is also amended to clarify that insurers must use information reflecting the changes for all policyholders to determine rate change information.

The title of the "historical and projected expense information" category in §5.9332(9) is amended to be "expense information."

Section 5.9333. Categories of Supplementary Rating Information. Amended §5.9333 deletes the opening language, which is not necessary to describe the section since the section title is clear.

Section 5.9334. Requirements for Rate and Rule Filing Submissions. Amended §5.9334 includes clarifying language, reflects that rules are filed under Division 6, and makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity. Subsection (e) has been split into two subsections, without changing the requirements of the rule, to make the requirements easier to read. The subsequent subsections in this section are redesignated because of this change.

Amendments to redesignated §5.9334(h)(10) reflect the change in the name for expense information in §5.9332(9). In the current rule, expense information is required in filings that change or replace current rates. However, expense information is needed for all filings, including those introducing new rates. A similar revision is made to redesignated subsection (h)(11), as profit provision information is also needed in filings introducing new rates.

Redesignated §5.9334(i) adds a requirement to include a side-by-side comparison or a mark up, if applicable, for short track filings. This requirement will help TDI quickly identify the proposed revisions in the filing.

The text of current §5.9334(i)(1), regarding disclosure of contact information in filings submitted through SERFF is deleted, and similar text has been proposed in §5.9310(g) in Division 4. The provision is more appropriate there because Division 4 includes general filing requirements that apply to filings made under Divisions 5, 6, 7, 8, and 9. The remaining paragraphs in the subsection have been renumbered as appropriate.

Current §5.9334(i), now redesignated as §5.9334(k), implements the amendments made by SB 978 to Insurance Code §2053.004, which require that filings for workers' compensation rates and supplementary rating information, including any supporting information, is public information subject to Government Code Chapter 552, including any applicable exception from required disclosure under that chapter.

Section 5.9335. Requests for Information. Amendments to §5.9335 include nonsubstantive changes for consistency with the agency's current style, and they reflect that rules are filed under Division 6.

Division 7. Requirements for Underwriting Guideline Filings.

Section 5.9340. Purpose. TDI made nonsubstantive editorial and formatting changes to §5.9340 to improve readability and conform the sections to the agency's current style and to improve the rule's clarity.

Section 5.9341. Definitions. TDI made nonsubstantive editorial and formatting changes to §5.9341 to improve readability and

conform the sections to the agency's current style and to improve the rule's clarity.

Section 5.9342. Filing Requirements. Amended §5.9342, regarding filing requirements for underwriting guideline filings, clarifies the lines of insurance for which insurers must file their underwriting guidelines. New subsection (h) reminds insurers that information used to classify risks to determine a rate must be filed in a rate and rule filing under Division 6. This information is supplementary rating information. This information may be filed in an underwriting guideline filing, as it is included in the definition of underwriting guideline in Insurance Code §38.002, but it must also be in the filer's rate and rule filing. Information used to decide whether to accept or reject an application for coverage must be included in the filer's underwriting guideline filings, but not its rate and rule filings.

Division 8. Requirements for Credit Scoring Model Filings for Personal Insurance.

Section 5.9351. Definitions. TDI made a nonsubstantive editorial change to improve readability.

Section 5.9352. Filing Requirements. In addition to clarifying language, amended §5.9352, which addresses the filing requirements for credit scoring models, adds two additional pieces of information--information about which insured's credit score is used for policies with more than one named insured, and how often the credit score is updated. This information will help TDI respond to inquiries from consumers, legislative offices, and other stakeholders.

Current §5.9352(c), which addresses disclosure of contact information in filings submitted through SERFF, has been deleted, and similar text has been proposed in §5.9310(g) of Division 4. The provision is more appropriate there because Division 4 includes general filing requirements that apply to filings made under Divisions 5, 6, 7, 8, and 9. However, the proposed amendment to §5.9310(g) does not include the text of the first sentence of current §5.9352(c), because Insurance Code §559.152 states that a credit scoring model "is public information; is not subject to any exceptions to disclosure under Government Code Chapter 552; and cannot be withheld from disclosure under any other law."

Current §5.9352(d) is redesignated as §5.9352(c), and the last sentence of the subsection is separated from the rest of the subsection and included as new subsection (d).

Division 9. Reduced Filing Requirements for Certain Insurers.

Section 5.9355. Purpose. Amended §5.9355 implements changes made by SB 1554. SB 1554 repealed Insurance Code Chapter 2251, Subchapter E, regarding the standard rate index for personal automobile insurance. The repeal was effective September 1, 2015.

Section 5.9356. Definitions. TDI made a nonsubstantive editorial change to §5.9356 to improve readability.

Section 5.9357. Filing Requirements. Amendments to §5.9357 are necessary to implement the repeal of Insurance Code Chapter 2251, Subchapter E, by SB 1554, regarding the standard rate index for personal automobile insurance. The amendments remove current Subsection (b), which references criteria in repealed Insurance Code §2251.205, regarding personal automobile insurers that issue personal automobile liability insurance policies only below 101 percent of the minimum limits required by Chapter 601, Transportation Code. The repealed text in Insurance Code §2251.205 was moved to Insurance Code §2251.1025. The remaining subsections are redesignated as appropriate.

In addition, as amended §5.9357 includes added language to clarify that insurers that qualify for reduced filing requirements under Division 9 do not have to provide supporting information, as described in the rule, unless it is requested. This does not change the current rule requirements, which are that requests for additional information, as outlined in §5.9335, apply to rate and rule filings under Division 9.

Current §5.9357(e), which addresses disclosure of contact information in filings submitted through SERFF, is deleted, and similar text has been proposed in §5.9310(g) in Division 4. The provision is more appropriate there because Division 4 includes general filing requirements that apply to filings made under Divisions 5, 6, 7, 8, and 9.

Division 10. Additional Filing Requirements for Certain County Mutual Insurance Companies.

Section 5.9360. Purpose. Amendments to §5.9360 reflect that rules are filed under Division 6, and make nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 5.9361. Additional Requirements. Amendments to §5.9361 reflect that rules are filed under Division 6, update references to earlier rules, and make nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Division 11. Certificates of Property and Casualty Insurance

Section 5.9370. Purpose and Scope. Amended §5.9370 makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 5.9371. Definitions. Amended §5.9371 alphabetizes the definitions and makes nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity.

Section 5.9372. Preparation and Submission of Certificate of Insurance Form Filings. TDI made nonsubstantive editorial and formatting changes to §5.9372 to conform to the agency's current style and to improve the rule's clarity.

Section 5.9373. Certificate of Insurance Form Filing Transmittal Information. Amended §5.9373 adds clarifying language to improve readability and understanding of the rule.

Section 5.9374. Incomplete Filings. Amended §5.9374 provides that TDI will inform a filer of why a filing is incomplete, rather than return the filing to the filer.

Section 5.9376. Restrictions on the Content of Certificates of Insurance. TDI made nonsubstantive editorial and formatting changes to §5.9376 to conform to the agency's current style and to improve the rule's clarity.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. J'ne Byckovski, chief actuary and director of the Property and Casualty Actuarial Office of the Regulatory Policy Division, has determined that during each year of the first five years that the amendments, new sections, and the repeal are in effect, there will be no fiscal impact on state or local government because of enforcing or administering the sections. The proposal

will have no measurable effect on local employment or the local economy.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments, repeals, and new sections are in effect, Ms. Byckovski expects the proposed amendments, repeals, and new sections will have the public benefit of increased compliance with filing requirements from filers, which will reduce their costs, improve government efficiency, and provide rules that are easier to understand and administer consistently.

Ms. Byckovski anticipates that the requirement for all filers to use SERFF is not likely to result in additional costs to the few filers who do not currently use it. Over 99 percent of filers currently use SERFF. Because most filers use SERFF, the cost to persons required to comply with the mandatory use of SERFF in the proposal are consistent with the costs filers currently bear in complying with the Filings Made Easy rules. The proposal requires information that filers should already be assembling to comply with current filing requirements. The cost to use SERFF, if any, should be minimal for the few filers that do not currently use the service.

Five insurers in Texas do not currently use SERFF. In early 2018, the renewals for one of these companies were purchased by a group whose companies currently make SERFF filings, and the largest non-SERFF user is currently making business plans to start using SERFF. Of the other three insurers, two submitted a total of six paper filings and the third submitted 15 paper filings (a total of 21 filings to TDI in 2017). This is a very small number of filings relative to the thousands of filings TDI receives annually through SERFF.

There is no licensing fee or set-up costs to use SERFF. NAIC provides a free, two-hour training tutorial, and additional online training by webinar is available for $495.00. This webinar is optional and, according to SERFF administrators, most users do not participate in it. The cost per filing in SERFF is $13.50. Block rates are available for filers who frequently use SERFF to submit their filings, depending on the number of filings transmitted through SERFF. The block rate for 500 filings is $9.50 each; 1,000 filings is $8.00 each; and 1,500 filings is $6.50 each.

The use of SERFF will adequately offset the cost of paper filings. Electronic filing through SERFF is more cost effective and efficient than paper filing. Paper filings require more employee time and participation and postage costs and they increase error rates, filing errors, or omissions that cannot be easily corrected. Submitting paper filings by email or fax does not always result in the transmission of all documents and submissions, which results in incomplete filings. The mandatory use of SERFF is not likely to be more expensive than paper filings for the companies that are not currently using it or have no immediate plans to do so.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

TDI has determined that the proposed amendments to §§5.9310; 5.9330 - 5.9335, 5.9340 - 5.9342, 5.9351, 5.9352, 5.9355 - 5.9357, 5.9360, 5.9361, 5.9370 - 5.9374, 5.9376; and new §5.9311 and §5.9312 will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities. The proposed amendments and new sections are based on underlying statutes and it is not feasible to waive or modify the requirements for small or micro businesses or rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis for these sections.

Section 5.9310(f) requires all filings under Divisions 5, 6, 7, 8, and 9 to be submitted through SERFF. The mandatory use of SERFF will affect less than 1 percent of insurers in Texas. Five insurers currently do not use SERFF to submit their Texas filings. However, as previously discussed, TDI expects that the use of SERFF is likely for two of the five insurers in the absence of this proposed rule. The remaining three insurers in Texas that do not currently use SERFF will be required to begin using it to submit filings under the proposed rules. These three companies submitted a total of 21 filings to TDI in 2017, which is a very small number of filings relative to the thousands of submissions TDI receives annually through SERFF. Electronic filing through SERFF is more cost effective and efficient than mailing, emailing, faxing, or hand-delivering paper filings to TDI. The use of SERFF will adequately offset the cost of submitting paper filings.

TDI has also determined that the proposed repeal and replacement of §§5.9320 - 5.9323, with new §§5.9320 - 5.9328, will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities. The proposed repeal and replacement with new sections in Division 5 is based on underlying statutes and it is not feasible to waive or modify the requirements for small or micro businesses or rural communities. The reorganization of §§5.9320 - 5.9328 to improve readability will not have an adverse economic effect or a disproportionate economic impact on small or micro businesses or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis for these sections except as indicated below.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a cost on regulated persons. Therefore, an examination of cost under Government Code §2001.0045(b) is not required.

GOVERNMENT GROWTH IMPACT STATEMENT. Ms. Byckovski has determined that each year of the first five years the proposed amendments and repeals are in effect, the rules will not positively or adversely affect this state's economy. The rules:

- will not create or eliminate a government program;

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

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

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

- will not increase or decrease the number of individuals subject to the rule's applicability;

- will not positively or adversely affect this state's economy;

- will create a new regulation in §5.9310(f); and

- will expand existing regulations regarding the filing requirements for insurers.

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

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal received by TDI no later than 5:00 p.m., central time, on February 11, 2019. Send your comment by email to ChiefClerk@tdi.texas.gov; or by mail to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. To request a public hearing, submit a written request before the end of the comment period by email to chiefclerk@tdi.texas.gov or by mail to the Office of the Chief Clerk, MC 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The request for public hearing must be separate from any comments and received by TDI no later than 5:00 p.m., central time, on February 11, 2019. If TDI holds a public hearing, TDI will consider all written and oral comments presented at the hearing.

DIVISION 4. FILINGS MADE EASY--TRANSMITTAL INFORMATION AND GENERAL FILING REQUIREMENTS FOR PROPERTY AND CASUALTY FORM, RATE AND RULE, UNDERWRITING GUIDELINE, AND CREDIT SCORING MODEL FILINGS

28 TAC §§5.9310 - 5.9312

STATUTORY AUTHORITY. The amendments to §5.9310 and new §5.9311 and §5.9312 are proposed under Insurance Code §§38.002, 38.003, 559.004, 559.151, 912.056, 2052.002, 2053.003, 2053.004, 2053.034, 2171.003, 2251.101, 2251.1025, 2251.107, 2251.252, 2301.001, 2301.006, 2301.009, 2301.053, 2301.055, 2301.056, 3502.101, 3502.104, 3502.108, and 36.001.

Section 38.002 requires each insurer writing personal automobile insurance or residential property insurance to file its underwriting guidelines with TDI and to ensure that the underwriting guidelines are sound, actuarially justified, substantially commensurate with the contemplated risk, and not unfairly discriminatory.

Section 38.003 provides that TDI may obtain a copy of the underwriting guidelines of an insurer for lines other than personal automobile insurance or residential property insurance.

Section 559.004 provides that the Commissioner "adopt rules that prescribe the allowable differences in rates charged by insurers due solely to the difference in credit scores."

Section 559.151 provides that an insurer that uses credit scores to underwrite and rate risks must file its credit scoring model or other credit scoring processes with TDI.

Section 912.056 provides that certain county mutual insurance companies that have appointed managing general agents, created districts, or organized local chapters to manage a portion of their business must, for each managing general agent, district, or local chapter program, file the rating information that the Commissioner requires by rule.

Section 2052.002 provides that in writing workers' compensation insurance, an insurance company may not use a form other than one prescribed by the Commissioner, and that before an insurance company may use a workers' compensation form that the Commissioner has not prescribed, the insurance company must submit it to and receive approval from TDI.

Section 2053.003 provides that each insurance company writing workers' compensation insurance must file with TDI all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in Texas.

Section 2053.004 provides that each filing, including any supporting information, for workers' compensation insurance is public information subject to Government Code Chapter 552.

Section 2053.034 provides that each insurer writing workers' compensation insurance must file with TDI a copy of its underwriting guidelines.

Section 2171.003 provides that an insurer must file a policy form for use with commercial group property insurance with the Commissioner before using the form.

Section 2251.101 provides that each insurer must file its rates, rating manuals, supplementary rating information, and additional information with TDI. It also provides that the Commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

Section 2251.1025 provides that the Commissioner adopt rules regarding filing requirements for certain personal automobile insurers with less than 3.5 percent of the market share of the personal automobile insurance market in this state.

Section 2251.107 provides that each filing, including any supporting information, under Chapter 2251 is public information subject to Government Code Chapter 552.

Section 2251.252 provides that an insurer is exempt from the filing requirements of Chapter 2251 if it or the rate it is filing meets certain criteria.

Section 2301.001 states that the purpose of Chapter 2301, Subchapter A, includes regulating insurance forms to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive.

Section 2301.006 provides that an insurer may not use policy forms, other than the standard forms adopted by the Commissioner, until the insurer files the forms with and receives approval by the Commissioner.

Section 2301.009 provides that filings under Chapter 2301, Subchapter A, are open to public inspection as of the date of filing.

Section 2301.053 provides that a form may not be used unless the form is written in plain language. A form is considered written in plain language if it achieves a minimum score established by the Commissioner on the Flesch reading ease test.

Section 2301.055 provides that the Commissioner may adopt reasonable and necessary rules to implement Chapter 2301, Subchapter B.

Section 2301.056 requires that declaration pages for residential property insurance policy forms list each type of deductible under the policy and state the exact dollar amount of each deductible.

Section 3502.101(a) provides that a mortgage guaranty insurer must file rate and supplementary rate information, and any changes to the rate or supplementary rate information with the Commissioner not later than 15 days before it uses the rate or supplementary rate information in this state. Section 3502.101(b) provides that the rate filing must include adequate supporting data; an explanation of the insurer's interpretation of any statistical data on which the insurer relied; an explanation and description of the methods used in making the rates; and certification of the appropriateness of the charges, rates, or rat-

ing plans based on reasonable assumptions and accompanied by adequate supporting information.

Section 3502.104 provides that a mortgage guaranty insurer must file forms, classifications, and rules with TDI.

Section 3502.108(a) provides that the Commissioner may adopt reasonable rules relating to the minimum standards for coverage under policy forms consistent with the purpose of Chapter 3502, relating to Mortgage Guaranty Insurance, and the public policy of this state. Section 3502.108(b) provides that TDI "may establish requirements for data and information filed under this chapter."

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §5.9310 and new §5.9311 and §5.9312 implement Insurance Code §§38.002, 38.003, 559.004, 559.151, 912.056, 2052.002, 2053.003, 2053.004, 2053.034, 2171.003, 2251.101, 2251.1025, 2251.107, 2251.252, 2301.001, 2301.006, 2301.009, 2301.053, 2301.055, 2301.056, 3502.101, 3502.104, 3502.108, and 36.001.

§5.9310. Property and Casualty Transmittal Information and General Filing Requirements.

(a) Purpose. The purpose of this division is to specify the transmittal information and general filing requirements for property and casualty form, [~~endorsement,~~] rate, and rule, underwriting guideline, and credit scoring model filings.

(b) Definitions. Terms not defined in this division may be defined in Insurance Code Chapters 2053, 2251, and 2301, and have the same meaning when used in this division. The following terms when used in this division have the following meanings unless the context indicates otherwise:

(1) Dual filing--A filing submitted for one line of insurance that may also be used in multi-peril insurance.

(2) Interline filing--A filing that may be used for more than one line of insurance submitted for:

(A) a policy jacket, declarations page, signature page, notice of cancellation, disclosure, schedule, general change form, company name change, or policyholder notice filed under Division 5 of this subchapter; or

(B) policy fees, service fees, and other fees that are charged or collected by the insurer under Insurance Code §550.001 or §4005.003 filed under Division 6 of this subchapter.

(3) Multi-peril insurance--Policies and rates for two or more lines of insurance that are subject to regulation under Insurance Code Chapters 2251 and 2301. This definition does not include a combination of coverages described in Insurance Code §2251.002 and §2301.002 and filed as commercial property insurance.

(4) NAIC--The National Association of Insurance Commissioners.

(5) Reference filing--A filing that references the use of policy forms, endorsements, rules, loss costs, rating manuals, other supplementary rating information, or credit scoring models that TDI has adopted, approved, or accepted.

(6) SERFF--The NAIC System for Electronic Rate and Form Filing.

(7) TDI--Texas Department of Insurance.

(8) TDI file number--The number TDI assigns to a filing.

[~~(1) TDI--Texas Department of Insurance.~~]

[~~(2) TDI file number--The number TDI assigns to a filing.~~]

[~~(3) Interline filing--A filing that may be used for more than one line of insurance submitted for:~~]

[~~(A) an endorsement, provided the endorsement does not have an impact on rates; or~~]

[~~(B) policy fees, service fees, and other fees that are charged or collected by the insurer under Insurance Code §550.001 or §4005.003.~~]

[~~(4) Reference filing--A filing that references the use of policy forms, endorsements, manual rules, loss costs, rating manuals, other supplementary rating information, or credit scoring models that TDI has adopted, approved, or accepted.~~]

[~~(5) Dual filing--A filing submitted for one line of insurance that may also be used in multi-peril insurance.~~]

[~~(6) Multi-peril insurance--Policies and rates for two or more lines of insurance that are subject to regulation under Insurance Code Chapters 2251 and 2301.~~]

(c) Transmittal information. Each filing must contain the following transmittal information:

(1) company name as used for financial reporting to the NAIC and company number assigned by the NAIC [~~the National Association of Insurance Commissioners (NAIC)~~];

(2) company group name and group NAIC number;

(3) whether the filing is new, or revises or replaces an existing filing;

(4) TDI file number of the revised or replaced filing;

(5) TDI file number for the previously approved policy that the proposed form will be attached to;

(6) [~~(5)~~] TDI file number of associated or companion filings of other filing types;

(7) [~~(6)~~] line of insurance:

(A) all filings must specify the line of insurance [~~to which the filing applies using either the appropriate type of insurance and subtype of insurance listed in the NAIC Uniform Property and Casualty Product Coding Matrix, or, in the case of filings not submitted through SERFF, the appropriate line of insurance listed in the Filings Made Easy Guide~~];

(B) interline filings must specify all lines of insurance to which the filing applies; and

(C) dual filings must indicate [~~multi-peril insurance and~~] the line of insurance to which the filing applies and the TDI file numbers for the applicable monoline and multi-peril filings;

(8) [~~(7)~~] type of filing;

(9) [~~(8)~~] proposed effective date; and

(10) [~~(9)~~] contact person, including name, telephone number, and mailing address[~~, and fax number~~].

(d) Filings Made Easy Guide. TDI maintains the Filings Made Easy Guide to help [~~assist~~] insurers submit [~~in submitting~~] filings and comply [~~complying~~] with statutory requirements. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

(e) Letter of authorization. A third-party representing an insurer on a filing must provide a letter of authorization signed by the insurer on the insurer's letterhead. A letter of authorization applies only to the filing with which it is submitted. [~~Copyright. Information included in rate filings under Insurance Code Chapter 2251 that is marked "copyright" may be made available for public disclosure in the same manner as information filed under Chapter 2251 that is not marked "copyright." Information that is marked "copyright" and that is included in rate filings under Insurance Code Chapter 2053 and Chapter 3502 and in form filings is not confidential and will be open for public inspection in the same manner as information not marked "copyright." Public disclosure methods may include posting filings on TDI's website.~~]

(f) Submission of filing. [~~Filing.~~] Filings under Divisions 5, 6, 7, 8, and 9 of this subchapter (relating to Filings Made Easy -[-] Requirements for Property and Casualty Policy Form and [,] Endorsement [, ~~and Manual Rule~~] Filings; Filings Made Easy -[-] Requirements for Rate and Rule Filings; Filings Made Easy--[-]Requirements for Underwriting Guideline Filings; Filings Made Easy --[-] Requirements for Credit Scoring Model Filings for Personal Insurance; and Filings Made Easy --[-] Reduced Filing Requirements for Certain Insurers[, ~~respectively~~]) must be submitted [~~either~~] through SERFF. [~~the System for Electronic Rate and Form Filing (SERFF); delivered to the Texas Department of Insurance, Property and Casualty Intake Unit, William P. Hobby Jr. State Office Building, 333 Guadalupe St., Austin, Texas 78701, Mail Code 104-3B; or mailed to the Texas Department of Insurance, Property and Casualty Intake Unit, Mail Code 104-3B, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(g) Public disclosure of contact information. To the extent that a filing includes company contact information, by submitting a filing the company affirmatively consents to the release and disclosure of its company contact information, including any email addresses. The filer also certifies that each person associated with an email address that appears in the filing has affirmatively consented to the release and disclosure of that email address.

§5.9311. Copyright, Public Inspection, and Confidential Filings.

(a) Copyright. Information included in filings that is marked "copyright" may be made available for public disclosure in the same manner as information that is not marked "copyright." Public disclosure methods may include posting filings on TDI's website or making them available for viewing through SERFF.

(b) Public inspection. Each filing submitted under Insurance Code Chapter 2301 or 3502, including any supporting information filed, will be open for public inspection as of the date of the filing. Each filing submitted under Insurance Code Chapter 2053 and 2251, including any supporting information filed, is public information subject to Government Code Chapter 552, including any applicable exception from required disclosure under that chapter.

(c) Confidential filings. If a filer marks its entire filing as confidential, TDI will reject the filing.

§5.9312. Personally Identifiable Information.

Filings must not include any policyholders' personally identifiable information. Filings that include this type of information may be rejected. As used in this subchapter, personally identifiable information means information that can be used either alone or in combination to distinguish an individual's identity. Examples of personally identifiable information include:

(1) any individual policyholder identification, including name, address, phone, or email;

(2) social security numbers;

(3) insurance policy numbers;

(4) drivers' license, identification card, vehicle identification, and license plate numbers;

(5) debit card, credit card, bank account, and routing numbers; and

(6) health information about a specific individual.

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 December 27, 2018.

TRD-201805570
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 5. FILINGS MADE EASY - REQUIREMENTS FOR PROPERTY AND CASUALTY POLICY FORM, ENDORSEMENT, AND MANUAL RULE FILINGS

28 TAC §§5.9320 - 5.9323

STATUTORY AUTHORITY. The repeal of 28 TAC Chapter 5, Subchapter M, Division 5 §§5.9320 - 5.9323 is proposed under Insurance Code §§2052.002, 2171.003, 2301.001, 2301.006, 2301.053, 2301.055, 2301.056, 3502.104, 3502.108, and 36.001.

Section 2052.002 provides that in writing workers' compensation insurance, an insurance company may not use a form other than one prescribed by the Commissioner, and that before an insurance company may use a workers' compensation form that the Commissioner has not prescribed, the insurance company must submit it to and receive approval from TDI.

Section 2171.003 provides that an insurer must file a policy form for use with commercial group property insurance with the Commissioner before using the form.

Section 2301.001 states that the purpose of Chapter 2301, Subchapter A, includes regulating insurance forms to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive.

Section 2301.006 provides that an insurer may not use policy forms, other than the standard forms adopted by the Commissioner, until the insurer files the forms with and receives approval by the Commissioner.

Section 2301.053 provides that a form may not be used unless the form is written in plain language. A form is considered written in plain language if it achieves a minimum score established by the Commissioner on the Flesch reading ease test.

Section 2301.055 provides that the Commissioner may adopt reasonable and necessary rules to implement Chapter 2301, Subchapter B (relating to Policy Forms for Personal Automobile Insurance Coverage and Residential Property Insurance Coverage).

Section 2301.056 requires that declaration pages for residential property insurance policy forms list each type of deductible under the policy and state the exact dollar amount of each deductible.

Section 3502.104 provides that a mortgage guaranty insurer must file forms, classifications, and rules with TDI.

Section 3502.108(a) provides that the Commissioner may adopt reasonable rules relating to the minimum standards for coverage under policy forms consistent with the purpose of Chapter 3502, relating to Mortgage Guaranty Insurance, and the public policy of this state.

Section 3502.108(b) provides that TDI "may establish requirements for data and information filed under this chapter."

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

CROSS REFERENCE TO STATUTE. The repeal of 28 TAC Chapter 5, Division 5, §§5.9320 - 5.9323 implements Insurance Code §§2052.002, 2171.003, 2301.001, 2301.006, 2301.053, 2301.055, 2301.056, 3502.104, 3502.108, and 36.001.

§5.9320. Required Information for the Preparation and Submission of Policy Form, Endorsement, and Manual Rule (Other than Rating Manual) Filings.

§5.9321. Request for Deemer Period Waiver.

§5.9322. Insurers Providing Coverage through a Purchasing Group.

§5.9323. Residential Property Declarations Page Forms.

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 December 27, 2018.

TRD-201805571
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 5. FILINGS MADE EASY--REQUIREMENTS FOR PROPERTY AND CASUALTY POLICY FORM AND ENDORSEMENT FILINGS

28 TAC §§5.9320 - 5.9328

STATUTORY AUTHORITY. New Division 5, §§5.9320 - 5.9328 is proposed under Insurance Code §§2052.002, 2171.003, 2301.001, 2301.006, 2301.053, 2301.055, 2301.056, 3502.104, 3502.108, and 36.001.

Section 2052.002 provides that in writing workers' compensation insurance, an insurance company may not use a form other than one prescribed by the Commissioner, and that before an insurance company may use a workers' compensation form that the Commissioner has not prescribed, the insurance company must submit it to and receive approval from TDI.

Section 2171.003 provides that an insurer must file a policy form for use with commercial group property insurance with the Commissioner before using the form.

Section 2301.001 states that the purpose of Chapter 2301, Subchapter A, includes regulating insurance forms to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive.

Section 2301.006 provides that an insurer may not use policy forms, other than the standard forms adopted by the Commissioner, until the insurer files the forms with and receives approval by the Commissioner.

Section 2301.053 provides that a form may not be used unless the form is written in plain language. A form is considered written in plain language if it achieves a minimum score established by the Commissioner on the Flesch reading ease test.

Section 2301.055 provides that the Commissioner may adopt reasonable and necessary rules to implement Chapter 2301, Subchapter B (relating to Policy Forms for Personal Automobile Insurance Coverage and Residential Property Insurance Coverage).

Section 2301.056 requires that declaration pages for residential property insurance policy forms list each type of deductible under the policy and state the exact dollar amount of each deductible.

Section 3502.104 provides that a mortgage guaranty insurer must file forms, classifications, and rules with TDI.

Section 3502.108(a) provides that the Commissioner may adopt reasonable rules relating to the minimum standards for coverage under policy forms consistent with the purpose of Chapter 3502, relating to Mortgage Guaranty Insurance, and the public policy of this state.

Section 3502.108(b) provides that TDI "may establish requirements for data and information filed under this chapter."

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

CROSS REFERENCE TO STATUTE. The proposed new Division 5, §§5.9320 - 5.9328 implement Insurance Code §§2052.002, 2171.003, 2301.001, 2301.006, 2301.053, 2301.055, 2301.056, 3502.104, 3502.108, and 36.001.

§5.9320. Purpose and Definitions.

(a) Purpose. The purpose of this division is to specify the filing requirements for property and casualty policy form and endorsement filings submitted under Insurance Code Chapters 2052, 2301, or 3502. All insurer and advisory organization filings must comply with the filing requirements of this division and any other applicable rules.

(b) Definitions. The definitions in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements) apply to this division.

§5.9321. General Filing Requirements.

(a) Filings must be submitted for only one line of insurance except for multi-peril and interline filings.

(b) Filings submitted under this division may not be combined with any other filing types submitted under this subchapter.

(c) Filings must contain the following:

(1) the transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements);

(2) a copy of the proposed policy forms or endorsements;

(3) a form number for each proposed form;

(4) an edition date for each proposed form, if applicable;

(5) the TDI file number for the previously approved policy to which the proposed form will be attached, if applicable;

(6) a form usage table that includes:

(A) the form name and form number for each proposed form; and

(B) information indicating whether each proposed form is optional, mandatory, or conditional mandatory. For conditional mandatory forms, the filer must submit an addendum that describes the conditions that make each form mandatory. For filings other than personal automobile, residential property, or personal multi-peril, the filer may describe the conditions elsewhere in the filing; and

(7) a memorandum that contains:

(A) a detailed explanation of the reasons for the filing;

(B) a description of the proposed policy forms or endorsements; and

(C) an explanation of each policy form and endorsement's use, which may include for example, the type of risk or risks for which the forms or endorsements will be used.

(8) All provisions required by statute, administrative rule, or Commissioner's order. Filers may add the required provisions to a policy form by including a Texas amendatory endorsement. The filing must include the amendatory endorsement, or the filing may reference an approved amendatory endorsement that applies to the policy forms in the filing.

(9) For amended policy forms or endorsements, copies of the previously approved or adopted policy forms or endorsements indicating the differences between the approved or adopted policy forms or endorsements and the filed policy forms or endorsements. New text must be underlined, and deleted text must be in brackets with a strikethrough. Alternatively, the changes can be indicated by other clearly identified or highlighted editorial notations referencing new and replaced text. The marked changes must be in a separate single document for each filed form.

(10) For personal automobile and residential property insurance, a filing must meet the statutory requirements for plain language in policies required by Commissioner's Order No. 92-0573, or any superseding Commissioner's order. The filing must also include the Flesch Reading Ease Test readability score for the filed forms or endorsements.

§5.9322. Additional Information.

(a) When reviewing each filing under this division, TDI may request additional information specific to the filing. This information may include:

(1) related forms or information;

(2) a summary of all policy provisions, including a detailed description and explanation of the coverages, limitations, exclusions, and conditions; or

(3) a coverage comparison to a similar policy form or endorsement that the Commissioner has approved or adopted containing a detailed explanation of all the differences including any restrictions in coverage, enhancements in coverage, or clarifications to the previously approved policy forms or endorsements.

(4) a coverage evaluation that contains a detailed explanation of the proposed changes including any restrictions in coverage, enhancements in coverage, or clarifications to approved or adopted policy forms or endorsements. The coverage evaluation may be provided in a side-by-side comparison showing any differences between the previously approved or adopted policy forms or endorsements and the proposed policy forms or endorsements.

(b) Filers must provide information requested by TDI under this section.

§5.9323. Requirements for Reference Filings.

(a) Reference filings for policy forms and endorsements should not include a copy of the referenced material.

(b) In addition to the transmittal information, a reference filing must include:

(1) the name of the insurance company or advisory organization whose filing is being referenced; and

(2) the TDI file number of the filing being referenced.

(c) For personal automobile, residential property, and personal multi-peril insurance, the filing must also include:

(1) a list of each form and endorsement that the insurer will use from each referenced filing; and

(2) a form usage table, as described in §5.9321(c)(6) of this title (relating to General Filing Requirements), that includes each form and endorsement that the insurer will use from each referenced filing.

(d) If a filer wants to change a form or endorsement approved for another insurer or an advisory organization, the filer may not submit the form as a reference filing. The filer must submit the amended form for approval with the information required by §§5.9321 - 5.9322 of this title (relating to General Filing Requirements and Additional Information).

§5.9324. Incomplete Filings.

(a) TDI will consider a filing incomplete if the filing does not comply with the filing requirements in §§5.9321 - 5.9323 of this title (relating to General Filing Requirements, Additional Information, and Requirements for Reference Filings).

(b) If TDI determines that a filing is incomplete, TDI will notify the filer and describe deficiencies in the filing and the additional information required to complete the filing. TDI may reject a filing that still has deficiencies on the date specified in the notice.

(c) A rejected filing:

(1) is not considered filed with TDI for the purposes of this division; and

(2) will not be reopened for purposes of resubmission.

(d) The deemer period does not begin until TDI receives a complete filing.

§5.9325. Request for Deemer Period Waiver.

By sending written notice to TDI, an insurer may waive the deadlines by which the Commissioner, under Insurance Code §2301.006, must approve or disapprove a form before it is deemed approved.

§5.9326. Insurers Providing Coverage through a Purchasing Group.

For policies effective on and after September 1, 2015, insurers that provide coverage to participants through a purchasing group must comply with the filing requirements of this division.

§5.9327. Residential Property Declarations Page Forms.

(a) Insurers must file residential property insurance policy declarations page forms for approval under this division. Declarations pages include renewal declarations pages, renewal certificates, amended declarations pages, and separate disclosure pages allowed under §5.9700 of this title (relating to Residential Property Declarations Pages and Deductible Disclosures).

(b) Filed declarations page forms must be completed with sample--not actual--policyholder information sufficient to demonstrate how the insurer will comply with this rule and Insurance Code §2301.056.

§5.9328. Insurers Writing Commercial Group Property Insurance.

As Insurance Code §2171.003 requires, insurers writing commercial group property insurance under Insurance Code §2171.002 must file a policy form with the Commissioner before using the form for a group of businesses or an association described by §2171.002 in which each member of the group or association is not a large risk.

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 December 27, 2018.

TRD-201805572
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 6. FILINGS MADE EASY--REQUIREMENTS FOR RATE AND RULE FILINGS

28 TAC §§5.9330 - 5.9335

STATUTORY AUTHORITY. The amendments to §§5.9330 - 5.9335 are proposed under Insurance Code §§559.004, 912.056, 2053.003, 2251.101, 2251.1025, 2251.252, 3502.101, 3502.104, 3502.108, and 36.001.

Section 559.004 provides that the Commissioner "adopt rules that prescribe the allowable differences in rates charged by insurers due solely to the difference in credit scores."

Section 912.056 provides that certain county mutual insurance companies that have appointed managing general agents, created districts, or organized local chapters to manage a portion of their business must, for each managing general agent, district, or local chapter program, file the rating information that the Commissioner requires by rule.

Section 2053.003 provides that each insurance company writing workers' compensation insurance must file with TDI all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in Texas.

Section 2251.101 provides that the Commissioner must adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

Section 2251.1025 provides that the Commissioner adopt rules regarding filing requirements for certain personal automobile insurers with less than 3.5 percent of the market share of the personal automobile insurance market in this state.

Section 2251.252 provides that an insurer is exempt from the filing requirements of Chapter 2251 if it or the rate it is filing meets certain criteria.

Section 3502.101(a) provides that a mortgage guaranty insurer must file rate and supplementary rate information, and any changes to the rate or supplementary rate information not later than 15 days before it uses the rate or supplementary rate information in this state. Section 3502.101(b) provides that the rate filing must include adequate supporting data; an explanation of the insurer's interpretation of any statistical data on which the insurer relied; an explanation and description of the methods used in making the rates; and certification of the appropriateness of the charges, rates, or rating plans based on reasonable assumptions and accompanied by adequate supporting information.

Section 3502.104 provides that a mortgage guaranty insurer must file forms, classifications, and rules with TDI.

Section 3502.108(a) provides that the Commissioner may adopt reasonable rules relating to the minimum standards for coverage under policy forms consistent with the purpose of Chapter 3502, relating to Mortgage Guaranty Insurance, and the public policy of this state. Section 3502.108(b) provides that TDI "may establish requirements for data and information filed under this chapter."

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §§5.9330 - 5.9335 implement Insurance Code §§559.004, 912.056, 2053.003, 2251.101, 2251.1025, 2251.252, 3502.101, 3502.104, 3502.108, and 36.001.

§5.9330. Purpose.

The purpose of this division is to specify requirements for rate and rule filings under Insurance Code Chapters 2053, 2251, and 3502. Rate and rule filings may include rates, prospective loss costs, loss cost multipliers, rating manuals, and other supplementary rating information. Rate and rule filings may also include information concerning policy fees, service fees, and other fees that are charged or collected by the insurer under Insurance Code §550.001 or §4005.003, or any other amounts collected by the insurer in connection with a policy. All insurer and advisory organization filings must comply with the filing requirements of this division and any other applicable rules adopted by the Commissioner.

§5.9331. Definitions.

(a) Terms not defined in this section, but that [~~which~~] are defined in Insurance Code Chapters [~~Chapter~~] 2053, 2251, or 3502, or in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements), have the same meaning when used in this division unless the context indicates otherwise.

(b) The following terms when used in this division have the following meanings, unless the context indicates otherwise:

(1) Disallowed expenses--Applies only to filings submitted under Insurance Code Chapter 2251. Disallowed expenses include the expenses in Insurance Code §2251.002(1-a) [~~§2251.002(1)~~]. Payments anticipated to be made to advisory organizations that are licensed to do business in Texas for services authorized by Insurance Code Chapter 1805, Subchapter B, are not disallowed expenses.

(2) Fees--Information concerning all policy fees, service fees, and other fees that are charged or collected by an insurer under Insurance Code §550.001 or §4005.003, or any other amounts collected by the insurer in connection with a policy, other than the premium. This information includes both the amount of the fees and the rules governing when the fees are charged and how they are earned.

(3) Insurer--An insurer authorized to write property and casualty insurance in Texas, including an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, association, Lloyd's plan, or other entity writing insurance in this state. The term includes an affiliate, as described by Insurance Code §823.003, if that affiliate is authorized to write insurance in Texas. The term includes an appointed managing general agent, district, or local chapter program of a county mutual insurance company described by Insurance Code §912.056(d) that manages a portion of that county mutual insurance company's business, independent of all other business of that county mutual insurance company, and that is to be treated as a separate insurer for the purposes of Insurance Code Chapters 544, 2251, 2253, and 2254, as provided in Insurance Code §912.056(e). The term does not include a farm mutual insurance company, an eligible surplus lines insurer under the Insurance Code, the Texas Windstorm Insurance Association, the Texas FAIR Plan Association, or the Texas Automobile Insurance Plan Association.

(4) Short track filing--A filing requiring limited supporting information to determine compliance with Texas statutes and rules. For example, a filing making an editorial change to a [~~rating~~] rule that does not result in the use of rates that are not on file, or a filing referring to certain advisory organization filings, may qualify as a short track filing. TDI determines whether a filing is eligible to be reviewed as a short track filing. The TDI website lists advisory organization filings that insurers may reference in a short track filing. [~~will maintain a list of qualifying types of filings on the TDI website.~~]

§5.9332. Categories of Supporting Information.

Categories [~~Supporting information is the documentation needed to verify compliance with Texas statutes and rules. Not every filing requires every category of supporting information defined in this section. Section 5.9334 of this title (relating to Requirements for Rate Filing Submissions) lists the categories of supporting information that different rate filings require. The categories~~] of supporting information include:

(1) Rate filing checklists. These are found in the Filings Made Easy Guide and show the information filers need to include with the filing.

(2) Actuarial memorandum. This memorandum describes the methodologies for determining each component used in developing the actuarial support and [~~, as well as~~] a qualitative discussion on the selections for each component. It includes an explanation for any changes in methodologies or any changes to the component selections from the previous analysis.

(3) Actuarial support. This type of support consists of sufficient documentation and analysis to allow a qualified actuary to understand and evaluate the rates, each component used in developing the rates, and the appropriateness of each material assumption. Actuarial support is divided into the following subcategories:

(A) Rate indications consist of the analyses the insurer relies on to support its filed rates, each component used to develop the rate indications, and support for each of these components, including the data and methodologies used by the insurer. Rate indications may be on an overall basis or by coverage, class, form, or peril when appropriate. Rate indications must include each of the following with documentation in support of each, to the extent applicable:

(i) premiums, on-level factors, and premiums at current rate level;

(ii) incurred and paid losses;

(iii) loss and claim development factors;

(iv) premium and loss trend factors;

(v) hurricane and nonhurricane catastrophe factors or loss provisions, including the definition of a catastrophe and how the definition has changed over the experience period used to calculate the provisions;

(vi) off-balance factors if there are changes in relativities, for example, discounts, surcharges, or territorial definitions;

(vii) the measure of credibility, the complement of credibility, the criteria for full credibility, and the method for determining partial credibility;

(viii) expenses, including general expenses; other acquisition expenses; commissions and brokerage expenses; taxes, licenses and fees; loss adjustment expenses; and expense offsets from fee income;

(ix) the net cost of reinsurance;

(x) for rates filed under Insurance Code Chapter 2251, profit provisions, including risk loads;

(xi) for rates filed under Insurance Code Chapters 2053 and 3502, profit and contingency provisions, including risk loads;

(xii) the effect on premiums of individual risk variations based on loss or expense considerations; and

(xiii) any other component used in developing a rate indication.

(B) Relativity analysis consists of both the analysis and support for the selected rating factors, including the loss experience [~~data~~] and methodologies used by the insurer to derive the indicated rating factors. Supporting information must include:

(i) the current relativity;

(ii) the indicated relativity;

(iii) support for the indicated relativities, including the loss experience [~~data~~] and methodologies used by the insurer to derive the [~~such~~] indications;

(iv) the selected relativity;

(v) support for the selected relativities if they differ from the indicated relativities; and

(vi) the percent change from current to selected relativity.

(C) Other actuarial support consists of both the analysis and support for the selected rates, including the loss experience [~~data~~] and methodologies used by the insurer to derive them. The support must clearly demonstrate why the proposed rates are not excessive, inadequate, or unfairly discriminatory. A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially

sound estimate of the expected value of all future costs associated with an individual risk transfer. These costs include claims, claim settlement expenses, operational and administrative expenses, and the cost of capital. [~~Examples include:~~]

~~(i)~~ ~~description and support for new discounts and surcharges;~~]

~~(ii)~~ ~~description and support for rates for new endorsements; and~~]

~~(iii)~~ ~~competitive analysis.~~]

(4) SERFF rate data. This data consists of all information necessary to complete the company rate information fields in SERFF. [~~For filers not using SERFF, this information includes the company name, the overall percentage and effective date of the last rate revision, the overall indicated change as a percent, the overall rate impact as a percent, the written premium change for the program, the number of policyholders affected for the program, the written premium for the program, and the maximum and minimum percentage change for the filing.~~]

(5) Policyholder impact information. Policyholder impact information must reflect the changes for all policyholders. This information consists of the following provided separately by [~~homeowners~~] form or [~~and personal automobile~~] coverage:

(A) a histogram that [~~which~~] graphically depicts the impact of the filed changes to policyholders in 5 percentage point intervals;

(B) the policy counts in each interval displayed in either the histogram or a separate table;

(C) the minimum and maximum policyholder impact; and

(D) a description of the changes that contributed to the minimum and maximum policyholder impact.

(6) Average rate change by county. This is the average impact of all changes included in a filing by county, provided separately by [~~homeowners~~] form or coverage.

(7) Rate change information. Rate change information must reflect the changes for all policyholders.

(A) For loss cost reference filings, rate change information consists of:

(i) the proposed percentage change in the underlying loss costs;

(ii) the change in the insurer's loss cost multiplier;

(iii) the combined change in the loss costs and the loss cost multipliers;

(iv) a six-year rate change history; and

(v) the effect that changes in fee income have on the total average rate change for all coverages and forms combined.

(B) For workers' compensation filings using classification relativities established under Insurance Code §2053.051, rate change information consists of:

(i) the percentage change in the underlying classification relativities;

(ii) the change in the insurer's deviation;

(iii) the combined change in the classification relativities and the insurer's deviation;

(iv) a six-year rate change history; and

(v) the effect that changes in fee income have on the total average rate change.

(C) For all other filings, rate change information consists of:

(i) the average proposed rate change for each applicable coverage or form;

(ii) the total average rate change for all applicable coverages and forms combined;

(iii) a six-year rate change history; and

(iv) the effect that changes in fee income have on the total average rate change for all applicable coverages and forms combined.

(8) Historical premium and loss information. This information consists of an insurer's most recent five-year experience, for both Texas and countrywide, of direct premiums written, direct premiums earned, direct losses and defense and cost containment expenses paid, direct losses and defense and cost containment expenses incurred, and the ratio of the direct losses and defense and cost containment expenses incurred to direct earned premiums. The Texas experience is the amounts, or a subset of the amounts, pertinent to the line of business reported on the Exhibit of Premiums and Losses (Statutory Page 14 Data) in the insurer's Annual Statement. The countrywide experience is the amounts, or a subset of the amounts, pertinent to the line reported on the insurer's Insurance Expense Exhibit (IEE), Part III in the insurer's Annual Statement.

(9) Expense [~~Historical and projected expense~~] information. This information consists of Texas experience[,] and, if applicable, countrywide experience. The loss adjustment expenses must be shown as a dollar amount and as [~~well as~~] a ratio to incurred [~~ratio-to-incurred~~] losses. All other expenses must be shown as a dollar amount and as [~~well as~~] a ratio to premium. All expense items must be on a direct basis.

(A) Three years of historical Texas experience must be included for commissions and brokerage expenses incurred; taxes, licenses, and fees incurred; losses incurred; and defense and cost containment expenses incurred. These must be the amounts, or a subset of the amounts, reported on the Exhibit of Premiums and Losses (Statutory Page 14 Data) in the insurer's Annual Statement.

(B) Three years of historical countrywide experience must be included for commissions and brokerage expenses incurred, other acquisition expenses incurred, general expenses incurred, losses incurred, defense and cost containment expenses incurred, and adjusting and other loss adjustment expenses incurred. These must be the amounts, or a subset of the amounts, reported in the insurer's IEE, Part III in the insurer's Annual Statement.

(C) Three years of historical countrywide experience must be included for each category of disallowed expenses. These must be the amounts reported in the insurer's response to the annual TDI Disallowed Expense Call. Other acquisition and general expenses, each adjusted to remove disallowed expenses, must be listed separately. The total adjusted general expense percentage must reflect any necessary adjustment due to the capping of general expenses at 110 percent of the industry median for the line of insurance.

(D) To the extent that the expense provisions differ from the historical expenses, the filing must provide additional support for the expense provisions underlying the rates. Provisions for commissions and brokerage expenses; other acquisition expenses; general ex-

penses; taxes, licenses, and fees; and profit and contingencies must be displayed and a sum computed. For filings submitted under Insurance Code Chapter 2251, the expense provisions must exclude disallowed expenses.

(E) When additional expense provisions are included, such as the net cost of reinsurance or an expense offset from fee income, the filing must include expected or historical experience. Support for provisions for the net cost of reinsurance may include reinsurance premiums, expected reinsurance recoverables, and a description of reinsurance coverage including attachment points and limits.

(10) Loss cost information for reference filings. This information consists of the following:

(A) the TDI file number of the loss costs being referenced;

(B) the derivation of the proposed loss cost multiplier including any loss cost modification factor and the following expense and profit provisions:

(i) commissions and brokerage expenses;

(ii) other acquisition expenses, adjusted to remove disallowed expenses;

(iii) general expenses, adjusted to remove disallowed expenses;

(iv) taxes, licenses, and fees; and

(v) underwriting profit and contingencies;

(C) supporting documentation for loss cost modification factors other than 1.00;

(D) the loss cost multiplier to be used as of the effective date of the filing;

(E) the loss cost multiplier used immediately before [~~prior to~~] the effective date of the filing; and

(F) the effective rate-level change due to any change in the loss cost multiplier.

(11) Profit provision information. This information consists of a description of the methodology, assumptions, and support for the assumptions used to arrive at the profit provisions underlying the proposed rates.

(12) A side-by-side comparison. This comparison must show any differences between the previously filed and the proposed rates, rating manual, [~~rating~~] rules, or other supplementary rating information.

(13) A mark up. This is a copy of the previously filed rates, rating manuals, [~~rating~~] rules, or other supplementary rating information indicating the differences between it and the revised version, with any new language or factors underlined and the deleted language or factors in brackets with a strikethrough, or other clearly identified or highlighted editorial notations referencing the new and replaced language or factors.

(14) Sample premium impacts by selected ZIP codes. These are sample premiums and premium changes based on all changes included in a filing for certain specified policy types and ZIP codes.

(15) Rate filing templates. These are found in the Filings Made Easy Guide and provide insurers with an optional means of providing certain supporting information and supplementary rating information.

(16) Other information. This includes any other information required by the Commissioner [~~commissioner~~] necessary to determine that the rates meet the rate standards.

§5.9333. Categories of Supplementary Rating Information.

Categories [~~Section 5.9334 of this title (relating to Requirements for Rate Filing Submissions) lists the categories of supplementary rating information that different rate filings require. The categories~~] of supplementary rating information include:

(1) Rating manual. This type of manual consists of any rating schedule, plan of rules, and rating rules. A rating manual may contain factors and relativities, including increased limits factors, classification relativities, deductible relativities, territory relativities, premium discounts, and other similar factors. A rating manual may also include some or all information in the remaining categories of supplementary rating information.

(2) Rating algorithm.

(3) Rating plan.

(4) Territory codes and descriptions.

(5) Classification system. This consists of any other criteria, guidelines, models, and methods that place individual risks into rating classifications, such as tiers, categories, or similar groupings, regardless of the name used.

(6) Factors and relativities, including increased limits factors, classification relativities, deductible relativities, territory relativities, premium discounts or surcharges, and other similar factors.

(7) Other information. This is any other information used by the insurer to determine the applicable premium for an insured.

§5.9334. Requirements for Rate and Rule Filing Submissions.

(a) Insurers must file any new rates or revisions to previously filed rates governed by Insurance Code Chapter 2053 at least 30 days before they become effective. The insurer must file any supplementary rating information not prescribed under Insurance Code Article 5.96.

(b) For rates governed by Insurance Code Chapter 2251, insurers must file any new rates, rating manuals, [~~rating~~] rules, all other supplementary rating information, and fees, or revisions to these items and [~~as well as~~] all other information required by this section. An insurer may use the information filed under this division on and after the date of the filing, unless the insurer is subject to prior approval under Insurance Code Chapter 2251, Subchapter D.

(c) Insurers must file any new rates and supplementary rating information or revisions to previously filed rates and supplementary rating information governed by Insurance Code Chapter 3502 at least 15 days before they become effective.

(d) All rate and rule filings must be submitted for only one line of insurance except for multi-peril and interline filings.

(e) [~~(d)~~] Each filing must include the transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements). [~~If the proposed effective date in the filing transmittal information changes, insurers~~]

(f) Insurers must inform TDI of a change in the [~~new proposed~~] effective date of a rate and rule filing on or before [~~prior to~~] the [~~original proposed~~] effective date in the filing.

(g) [~~(e)~~] Each filing must include a filing memorandum that explains the purpose of the filing and provides all material background details relating to the filing, including a statement on the overall impact of the filing. The filing memorandum must briefly describe each

change to the rates, rating manuals, [~~rating~~] rules, any other supplementary rating information and fees used by the insurer, and briefly describe the supporting information provided for each change. A brief summary of any related policy form or endorsement filings, including the coverages, limitations, and exclusions, must be included.

(h) [~~(f)~~] Except as provided in Division 9 of this subchapter (relating to Filings Made Easy --[-] Reduced Filing Requirements for Certain Insurers), or subsection (i)[~~(g)~~] of this section, each filing must include supporting information. Sufficient supporting information is necessary for TDI to establish that a filing produces rates that are not excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which they apply. Insurers must provide sufficient documentation to justify specific rates or revisions they are proposing. To the extent the information originally submitted in a rate and rule filing is insufficient, TDI may request additional information as deemed necessary by TDI or the Commissioner. [~~commissioner.~~] Each filing must contain the following items:

(1) a completed rate filing checklist;

(2) rate change information;

(3) SERFF rate data;

(4) loss cost information, if the filing references an advisory organization loss cost filing;

(5) an actuarial memorandum;

(6) actuarial support appropriate to the rating information being filed, as specified in subparagraphs (A) - (C) of this paragraph:

(A) All filings that propose changes to relativities, such as territory or class, and [~~as well as~~] those implied by [~~applied through~~] discounts, surcharges, or tiers, must include relativity analyses. This requirement applies when the proposed rate changes vary across a characteristic, regardless of presentation. The related territory codes and descriptions, classification systems and descriptions, or rules must also be included.

(B) All except the following filings must include rate indications:

(i) filings for new rates that will not replace, modify, or supersede any existing rates, unless the rates are derived from the experience of an affiliate, including an eligible surplus lines insurer;

(ii) fee filings; or

(iii) filings containing changes only to supplementary rating information with no overall rate impact. Examples include filings with no overall rate impact that contain only items such as relativity changes or rates for endorsements.

(C) Filings must include other actuarial support when neither the relativity analysis in subparagraph (A) nor the rate indications in subparagraph (B) of this paragraph [~~§5.9334(f)(6)~~] apply;

(7) policyholder impact information for owner-occupied homeowner and personal automobile filings that include changes that will result in a difference between the minimum and maximum policyholder impact that is greater than 5 percent;

(8) the average rate change by county for owner-occupied homeowners rate filings;

(9) historical premium and loss information, if the filing changes or replaces existing rates;

(10) [~~historical and projected~~] expense information [~~, if the filing changes or replaces existing rates~~]; and

(11) profit provision information [~~, if the filing changes or replaces existing rates~~].

(i) [~~(g)~~] Instead of the items in subsection (h)[~~(f)~~] of this section, short track filings must include:

(1) a completed rate filing checklist;

(2) rate change information; [~~and~~]

(3) SERFF rate data; and[~~.~~]

(4) a side-by-side comparison or a mark up, if applicable.

(j) [~~(h)~~] Each filing submitted must be legible, accurate, internally consistent, complete, and contain all required documents. In each filing:

(1) each table must be clearly labeled, including titles and column and row headings, so as to clearly identify the contents;

(2) row and column headings must be repeated on each page of tables displayed on multiple pages;

(3) all pages must print to at least 10-point font in black ink, unless the pages are a mark up;

(4) text shading, other than [~~with the exception of~~] yellow highlighting, may not be used; and

(5) each page should include a page number or other unique identifier.

(k) [~~(i)~~] Paragraphs (1) - (3)[~~(4)~~] of this subsection address public information.

[~~(1) To the extent that a filing submitted through SERFF includes contact information, the filer affirmatively consents to the release and disclosure of the contact information, including any email addresses. The filer also certifies that each person associated with an email address that appears in the filing has affirmatively consented to the release and disclosure of that email address.~~]

(1) [~~(2)~~] If an insurer believes a portion of the information required to be filed under Insurance Code Chapter 2053 or Chapter 2251 is confidential and excepted from disclosure under Government Code Chapter 552, the insurer must mark each page excepted.

(2) [~~(3)~~] For filings submitted under Insurance Code Chapters [~~Chapter~~] 2053 or 2251 , that include information that is [~~and that are~~] marked confidential, TDI will request an attorney general decision under Government Code Chapter 552 before making the information [~~filings~~] open for public inspection. TDI does not consider the following excepted from disclosure under Government Code Chapter 552: loss cost multipliers, rates, rating factors and relativities, rating manuals, fees, or [~~and~~] summary information about the [~~rate~~] filing, including date filed, rate impact, effective dates, or [~~and~~] a summary of the changes. TDI does not consider the following categories of supporting information excepted from disclosure under Government Code Chapter 552: rate change information, SERFF rate data, average rate change by county, sample premium impacts by selected ZIP codes, historical premium and loss information, or [~~and~~] historical expense information.

(3) [~~(4)~~] Each filing submitted under Insurance Code Chapter [~~Chapters 2053 and~~] 3502, including any supporting information filed, will be open for public inspection as of the date of the filing.

(l) [~~(j)~~] The insurer is responsible for ensuring that its filing complies with Texas statutes and rules.

(m) [~~(k)~~] TDI maintains the Filings Made Easy Guide to help [~~assist~~] insurers comply [~~in complying~~] with Texas statutes and rules.

Insurers may refer to the Filings Made Easy Guide for rate filing templates or exhibits that insurers can use to display necessary supporting information required in subsection (h)[(f)] of this section. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

(n) [(l)] Filings under this division may not be combined with any other filing types [filings] submitted under this subchapter.

§5.9335. Requests for Information.

(a) When reviewing each filing under this division, TDI may request additional supplementary rating information and supporting information.

(b) To be considered fully responsive to a request for information, an insurer's responses must:

(1) fully address all of the requests and questions in a manner that is clear and in sufficient detail to allow a qualified actuary to understand and evaluate the material and any explanations provided;

(2) contain appropriate supporting data and calculations, including material assumptions, with sufficient narrative to clearly explain the methodology used, the nature and source of the data, and [as well as] any conclusions drawn; and

(3) provide an explanation of any apparent anomalies in the data and how the insurer mitigated or accounted for them in arriving at the proposed rates and rules.

(c) TDI may request that an insurer file a comprehensive set of rates, rating manuals, [rating] rules, fees, and all other supplementary rating information when filing a revision to previously filed rates, rating manuals, [rating] rules, fees, and all other supplementary rating information.

(d) For each filing under Insurance Code Chapter 2251, TDI may request additional supplementary rating information and supporting information five times each. The insurer must respond by the date specified in the request. Correspondence requesting information that should have been included in the response, or clarifications of the information included in the response, will not constitute a new request for information.

(e) Requests that are necessary to make the filing complete are not a request for information under subsection (d) of this section. Examples of this type of request include:

(1) requests for information required by §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements);

(2) requests for information required by §5.9334 of this title (relating to Requirements for Rate and Rule Filing Submissions); and

(3) requests arising from discrepancies in the filing.

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 December 27, 2018.

TRD-201805573
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 7. FILINGS MADE EASY--REQUIREMENTS FOR UNDERWRITING GUIDELINE FILINGS

28 TAC §§5.9340 - 5.9342

STATUTORY AUTHORITY. The amendments to §§5.9340 - 5.9342 are proposed under Insurance Code §§38.002, 38.003, 2053.034, and 36.001.

Section 38.002 requires each insurer writing personal automobile insurance or residential property insurance to file its underwriting guidelines with TDI and to ensure that the underwriting guidelines are sound, actuarially justified, substantially commensurate with the contemplated risk, and not unfairly discriminatory.

Section 38.003 provides that TDI may obtain a copy of the underwriting guidelines of an insurer for lines other than personal automobile insurance or residential property insurance.

Section 2053.034 provides that each insurer writing workers' compensation insurance must file with TDI a copy of its underwriting guidelines.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §§5.9340 - 5.9342 implement Insurance Code §§38.002, 38.003, 2053.034, and 36.001.

§5.9340. Purpose.

The purpose of this division is to specify underwriting guideline filing requirements under Insurance Code Chapter 38 [§38.002 and §38.003,] and Chapter 2053.

§5.9341. Definitions.

The following definitions apply to underwriting guideline filings under this division:

(1) the [The] definitions [set forth] in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements); [apply to this division.]

(2) the [The] definitions [set forth] in Insurance Code §38.002 apply to insurers filing underwriting guidelines for personal automobile or residential property insurance[.];

(3) the [The] definitions [set forth] in Insurance Code Chapter 2053 apply to insurers filing underwriting guidelines for workers' compensation insurance; and[.]

(4) the [The] definitions [set forth] in Insurance Code §38.003 apply to insurers filing underwriting guidelines for lines of property and casualty insurance not subject to Insurance Code §38.002.

§5.9342. Filing Requirements.

(a) An insurer writing personal automobile, residential property, or workers' compensation insurance must file with TDI:

(1) at least once every three calendar years on or before March 1, beginning March 1, 2004, a written, comprehensive set of each underwriting guideline used by the insurer or the insurer's agent; and

(2) not later than the 10th day after the underwriting guideline has changed, a written update to the underwriting guideline clearly identifying each section of the previously filed underwriting guideline that has changed.

(b) For purposes of compliance with this section, an oral or electronic underwriting guideline must be converted to written form.

(c) An insurer group or group of affiliated insurers may file one set of underwriting guidelines or update to underwriting guidelines on behalf of individual insurers in the group under the requirements of this section if the group clearly identifies which underwriting guidelines apply to each insurer within the group.

(d) An insurer that files underwriting guidelines or updates to underwriting guidelines under this section must submit the filing transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements) with [~~the filing for~~] each underwriting guideline filing [~~and update~~].

(e) All filings for underwriting guidelines must relate to only one line of insurance.

(f) Underwriting guidelines contemplated by Insurance Code §38.003, other than workers' compensation insurance, are required only if requested. Underwriting guidelines submitted in response to a request under Insurance Code §38.003 must be filed in compliance with subsections (b), (c), and (d) of this section.

(g) Filings under this division may not be combined with any other filings submitted under this subchapter.

(h) Information used to classify risks for the purpose of determining a rate must be filed under Division 6 of this title (relating to Filings Made Easy--Requirements for Rate and Rule Filings), even if the information is included in an underwriting guideline filing under this division.

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 December 27, 2018.

TRD-201805574
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 8. FILINGS MADE EASY--REQUIREMENTS FOR CREDIT SCORING MODEL FILINGS FOR PERSONAL INSURANCE

28 TAC §5.9351, §5.9352

STATUTORY AUTHORITY. The amendments to §5.9351 and §5.9352 are proposed under Insurance Code §§559.004, 559.151, and 36.001.

Section 559.004 provides that the Commissioner "adopt rules that prescribe the allowable differences in rates charged by insurers due solely to the difference in credit scores."

Section 559.151 provides that an insurer that uses credit scores to underwrite and rate risks must file its credit scoring model or other credit scoring processes with TDI.

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

CROSS REFERENCE TO STATUTE. The proposed amendments to §5.9351 and §5.9352 implement Insurance Code §§559.004, 559.151, and 36.001.

§5.9351. Definitions.

(a) The definitions [~~set forth~~] in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements) apply to this division. Words and terms not defined in this division may be defined in Insurance Code Chapter 559 and will have the same meaning when used in this division.

(b) Credit scoring model--The algorithm, computer application, model, or other process that is based on credit information used to derive a credit score or insurance score.

§5.9352. Filing Requirements.

(a) All credit scoring models must be filed before they can be used. Insurers referencing credit scoring models that have been filed with TDI by another entity on behalf of an insurer in this state must specify the exact name of the credit scoring model being referenced instead of filing the model itself. Insurers making independent credit scoring model filings must file the entire model, including definitions.

(b) An insurer that files a credit scoring model or references a model that has been filed with TDI by another entity on behalf of another insurer in this state must submit the following information with the filing:

(1) the filing transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements);

(2) whether the insurer uses the credit score [~~resulting from the model~~] for underwriting, rating, or tiering; [~~and~~]

(3) for policies with more than one named insured, which insured's credit score is used;

(4) how often the credit score is updated; and

(5) [~~(3)~~] a completed questionnaire, used to verify compliance with Insurance Code Chapter 559.

[~~(c) Each filing, and any supporting information filed with it, is open to public inspection as of the date of the filing. To the extent that a filing submitted through SERFF includes contact information, the filer affirmatively consents to the release and disclosure of the contact information, including any email addresses. The filer also certifies that each person associated with an email address that appears in the filing has affirmatively consented to the release and disclosure of that email address.~~]

(c) [~~(d)~~] TDI maintains the Filings Made Easy Guide to help [~~assist~~] insurers comply [~~in complying~~] with Texas statutes and rules. Insurers may refer to the Filings Made Easy Guide for the questionnaire described in subsection (b)(5)[~~(b)(3)~~] of this section. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

(d) Filings under this section may not be combined with any other filing type [~~filings~~] submitted under this subchapter.

(e) All filings for credit scoring models must relate to only one line of insurance.

(f) An insurer must refile a credit scoring model before the insurer may use the credit scoring model for a line of insurance not identified in the credit scoring model's original filing.

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 December 27, 2018.

TRD-201805575
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 9. FILINGS MADE EASY--REDUCED FILING REQUIREMENTS FOR CERTAIN INSURERS

28 TAC §5.9355 - 5.9357

STATUTORY AUTHORITY. The amendments to §§5.9355 - 5.9357 are proposed under Insurance Code §§2251.101, 2251.1025, 2251.252, and 36.001.

Section 2251.101 provides that the Commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

Section 2251.1025 provides that the Commissioner adopt rules regarding filing requirements for certain personal automobile insurers with less than 3.5 percent of the market share of the personal automobile insurance market in this state.

Section 2251.252 provides that an insurer is exempt from the filing requirements of Chapter 2251 if it or the rate it is filing meets certain criteria.

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

CROSS REFERENCE TO STATUTE. The amendments to §§5.9355 - 5.9357 implement Insurance Code §§2251.101, 2251.1025, 2251.252, and 36.001.

§5.9355. Purpose.

The purpose of this division is to specify requirements for certain insurers who qualify for reduced rate filing requirements under the provisions of Insurance Code Chapter 2251, Subchapter C [~~Subchapter E~~] or F.

§5.9356. Definitions.

The definitions [~~set forth~~] in §5.9331 of this title (relating to Definitions) apply to this division.

§5.9357. Filing Requirements.

(a) Insurers [~~County mutual insurers~~] writing [~~nonstandard~~] personal automobile insurance. Insurers [~~County mutual insurers~~] required to file under the provisions of Insurance Code Chapter 2251 may make rate and rule filings for personal automobile insurance according to the requirements described in this subsection if they meet the criteria under Insurance Code §2251.1025(a). [~~issue policies only at nonstandard rates as defined under Insurance Code §2251.204, and if the insurer and the insurer's affiliated companies or group have a market share of less than 3.5 percent.~~] Insurers that qualify to file under this subsection must file in compliance with Division 6 of this subchapter (relating to Filings Made Easy--[-]Requirements for Rate and Rule Filings) with the following modifications:

(1) Insurers must include a Certification of §2251.1025 [~~Sections 2251.201 - 2251.204~~] Exemption Compliance (EC-2), found in the Filings Made Easy Guide, with each filing. [~~Instead of submitting the EC-2, an insurer may submit a certification of compliance which certifies that the insurer writes only at nonstandard rates and that the insurer and the insurer's affiliated companies or group have a market share of less than 3.5 percent.~~]

(2) Insurers are not required to [~~comply with~~] file supporting information described in §5.9334(h)[~~(f)~~](5), (6), (9), (10), and (11) of this title (relating to Requirements for Rate and Rule Filing Submissions), unless requested.

[~~(b) Insurers writing personal automobile insurance. An insurer that writes personal automobile insurance and meets the criteria in Insurance Code §2251.205 may make rate filings for personal automobile insurance according to the requirements specified in subsection (a) of this section if:~~]

[~~(1) the insurer, along with the insurer's affiliated companies or group, issues personal automobile liability insurance policies only below 101 percent of the minimum limits required by the Transportation Code Chapter 601; and~~]

[~~(2) the insurer, along with the insurer's affiliated companies or group, has a market share of less than 3.5 percent of the personal automobile insurance market in this state.~~]

(b) [~~(c)~~] Insurers writing residential property in underserved areas. In compliance with Insurance Code §2251.252(c), insurers otherwise exempt from the rate and rule filing requirements of Chapter 2251 must submit rate and rule filings in compliance with this subsection. Insurers who qualify to file under this subsection must file in compliance with Division 6 of this subchapter:

(1) Insurers must include a Certification of §2251.251 [~~Section 2251.251~~] and §2251.252 [~~Section 2251.252~~] Exemption Compliance (EC-1), found in the Filings Made Easy Guide.

(2) Insurers are not required to [~~comply with~~] file supporting information described in §5.9334(h)[~~(f)~~](5), (6), (9), (10), and (11) of this title, unless requested.

(c) [~~(d)~~] Additional provisions. The following provisions apply to any rate and rule filing submitted under subsection (a) or [~~,~~] (b)[~~, or (c)~~] of this section:

(1) The reduced filing requirements provided under this division do not affect the requirements under §5.9941 of this title (relating to Differences in Rates Charged Due Solely to Difference in Credit Scores) and §5.9960 of this title (relating to [~~Differences in Rates Charged Due Solely to Difference in Credit Scores and~~] Exception to Rating Territory Requirements under [~~Insurance Code~~] §2253.001 of the Insurance Code).

(2) Requests for additional information are as outlined in §5.9335 of this title (relating to Requests for Information).

[~~(e) Public information. To the extent that a filing submitted through SERFF includes contact information, the filer affirmatively~~

~~consents to the release and disclosure of the contact information, including any email addresses. The filer also certifies that each person associated with an email address that appears in the filing has affirmatively consented to the release and disclosure of that email address.]~~

(d) [~~(f)~~] Filings Made Easy Guide. TDI maintains the Filings Made Easy Guide to help [~~assist~~] insurers comply [~~in complying~~] with Texas statutes and rules. Insurers may refer to the Filings Made Easy Guide for the Certification of §[~~Section~~]2251.251 and §[~~Section~~]2251.252 Exemption Compliance (EC-1) form referenced in subsection (b)(1)[~~(c)(1)~~] of this section and the Certification of §2251.1025 [~~Sections 2251.201 - 2251.204~~] Exemption Compliance (EC-2) form referenced in subsection (a)(1) of this section. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

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 December 27, 2018.

TRD-201805576
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 10. FILINGS MADE EASY--ADDITIONAL FILING REQUIREMENTS FOR CERTAIN COUNTY MUTUAL INSURANCE COMPANIES

28 TAC §5.9360, §5.9361

STATUTORY AUTHORITY. The amendments to §5.9360 and §5.9361 are proposed under Insurance Code §§912.056, 2251.101, and 36.001.

Section 912.056 provides that certain county mutual insurance companies that have appointed managing general agents, created districts, or organized local chapters to manage a portion of their business must, for each managing general agent, district, or local chapter program, file the rating information that the Commissioner requires by rule.

Section 2251.101 provides that the Commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

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

CROSS REFERENCE TO STATUTE. The amendments to §5.9360 and §5.9361 implement Insurance Code §§912.056, 2251.101, and 36.001.

§5.9360. Purpose.

The purpose of this division is to specify filing requirements in addition to those in Division [~~Divisions~~] 4 [~~and 6~~] of this subchapter (relating to Filings Made Easy --[-] Transmittal Information and General Filing Requirements for Property and Casualty Form, Rate and Rule, Underwriting Guideline, and Credit Scoring Model Filings) and Division 6 (relating to Filings Made Easy --[-] Requirements for Rate and Rule Filings[, ~~respectively~~]) for:

(1) a county mutual insurance company described by Insurance Code §912.056(d); and

(2) an appointed managing general agent, district, or local chapter program of a county mutual insurance company described by Insurance Code §912.056(d) that manages a portion of that county mutual insurance company's business independent of all other business of that county mutual insurance company, and that is to be treated as a separate insurer for the purposes of Insurance Code Chapters 544, 2251, 2253, and 2254 as provided in Insurance Code §912.056(e).

§5.9361. Additional Requirements.

(a) Filing transmittal. In addition to the information required by Division 4 of this subchapter (relating to Filings Made Easy --[-] Transmittal Information and General Filing Requirements for Property and Casualty Form, Rate and Rule, Underwriting Guideline, and Credit Scoring Model Filings), the following information must be included:

(1) the name and license number of the managing general agent, district, or local chapter of a county mutual insurance company; and

(2) contact information for the county mutual insurance company, if the county mutual insurance company's contact information has not already been provided under §5.9310(c)(10)[~~(9)~~] of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements).

(b) Rate and rule filings.

(1) All rate and rule filings must be made directly by the county mutual insurance company on the county mutual insurance company's letterhead, unless the county mutual insurance company submits written notice with the filing authorizing the submission of rate filings by the managing general agent, district, or local chapter.

(2) Each rate and rule filing must include:

(A) all information required under §5.9334 of this title (relating to Requirements for Rate and Rule Filing Submissions), which must be specific to the managing general agent, district, or local chapter; and

(B) a list of policy forms and endorsements, including their name, number, and the TDI file number, used by the managing general agent, district, or local chapter. The submission of a list of policy forms and endorsements under this subsection does not constitute a form filing under Insurance Code Chapter 2301.

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 December 27, 2018.

TRD-201805577
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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DIVISION 11. FILINGS MADE EASY--CERTIFICATES OF PROPERTY AND CASUALTY INSURANCE

28 TAC §§5.9370 - 5.9374, 5.9376

STATUTORY AUTHORITY. The amendments to §§5.9370 - 5.9374 and 5.9376 are proposed under Insurance Code §§1811.003, 1811.052, 1811.053, 1811.101, 1811.104, and 36.001.

Section 1811.003 allows the Commissioner to adopt rules necessary or proper to accomplish the purposes of Insurance Code Chapter 1811.

Section 1811.052 states that an insurer or an agent may not issue a certificate of insurance unless the certificate has been filed with and approved by TDI or is a standard form deemed approved by TDI under §1811.103.

Section 1811.053 states that a person may not alter or modify a certificate of insurance form approved under §1811.101 unless the alteration or modification is approved by TDI.

Section 1811.101 states that an insurer or agent may not deliver or issue for delivery in this state a certificate of insurance unless the certificate has been filed with and approved by the Commissioner and contains the phrase "for information purposes only" or similar language.

Section 1811.104 provides that a certificate of insurance form and any supporting information filed with TDI is open to public inspection as of the date of the filing.

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

CROSS REFERENCE TO STATUTE. The amendments to §§5.9370 - 5.9374 and 5.9376 implement Insurance Code §§1811.003, 1811.052, 1811.053, 1811.101, 1811.104, and 36.001.

§5.9370. Purpose and Scope.

(a) This division specifies the filing requirements for certificates of property and casualty insurance submitted under [~~pursuant to~~] Insurance Code Chapter 1811[~~of the Insurance Code~~]. It also consolidates and explains the restrictions that apply to the content of certificates of insurance.

(b) Nothing in this division prohibits a certificate holder from requesting a copy of the subject policy or endorsements.

(c) Nothing in this division applies to certificates or evidence forms exempted from the filing requirements under [~~pursuant to~~] Insurance Code §1811.002(b), including:

(1) a statement, summary, or evidence of property insurance required by a lender in a lending transaction involving a mortgage, lien, deed of trust, or any other security interest in real or personal property as security for a loan;

(2) a certificate issued under a group or individual policy for life insurance, credit insurance, accident and health insurance, long-term care benefit insurance, or Medicare supplement insurance or an annuity contract; or

(3) standard proof of motor vehicle liability insurance.

(d) Nothing in this division applies to negotiable or transferable certificates or evidence forms pertaining to marine insurance.

(e) Nothing in this division applies to a certificate or evidence form pertaining to a nonadmitted insurance policy sold to, solicited by, or negotiated with an insured whose home state is not Texas. In this subsection, "home state" has the same definition as in Insurance Code §226.051.

§5.9371. Definitions.

(a) Words and terms not defined in this division have the same meaning as in Insurance Code Chapter 1811[~~of the Insurance Code~~].

(b) Unless the context indicates otherwise, this division uses the following definitions:

(1) Certificate holder--A person, other than a policyholder, who is designated on a certificate of insurance as a certificate holder or to whom a certificate of insurance has been issued by an insurer or agent at the request of the policyholder.

(2) Certificate of insurance--A document, instrument, or record, including an electronic record, no matter how titled or described, that is executed by an insurer or agent and issued to a third person not a party to the subject insurance contract, as a statement or summary of property or casualty insurance coverage. The term does not include an insurance binder or policy form, or any document that describes insurance coverage that is merely promised or expected to exist in the future, whether titled as an affidavit, insurance verification form, or otherwise.

(3) Commissioner--The Commissioner of Insurance.

(4) Company--The name of the entity filing the certificate of insurance form. If a third party is filing the certificate of insurance form, the company name is the name of the entity for which the third party is filing the certificate of insurance form, not the name of the third-party filer.

(5) FEIN--Federal Employer Identification Number.

(6) Insurance Code--The Texas Insurance Code.

(7) NAIC--The National Association of Insurance Commissioners.

(8) SERFF--The NAIC System for Electronic Rate and Form Filing.

(9) TDI--The Texas Department of Insurance.

~~[(1) Certificate of insurance--A document, instrument, or record, including an electronic record, no matter how titled or described, that is executed by an insurer or agent and issued to a third person not a party to the subject insurance contract, as a statement or summary of property or casualty insurance coverage. The term does not include an insurance binder or policy form, or any document that describes insurance coverage that is merely promised or expected to exist in the future, whether titled as an affidavit, insurance verification form, or otherwise.]~~

~~[(2) Certificate holder--A person, other than a policyholder, who is designated on a certificate of insurance as a certificate holder or to whom a certificate of insurance has been issued by an insurer or agent at the request of the policyholder.]~~

~~[(3) Company--The name of the entity filing the certificate of insurance form. If a third party is filing the certificate of insurance form, the company name is the name of the entity for which the third party is filing the certificate of insurance form, not the name of the third party filer.]~~

[(4) Commissioner--The commissioner of insurance.]

[(5) TDI--The Texas Department of Insurance.]

[(6) Insurance Code--The Texas Insurance Code.]

[(7) FEIN--Federal Employer Identification Number.]

[(8) NAIC--The National Association of Insurance Commissioners.]

[(9) SERFF--The NAIC System for Electronic Rate and Form Filing.]

§5.9372. Preparation and Submission of Certificate of Insurance Form Filings.

(a) Approval required. A certificate of insurance issued on property or casualty operations or a risk located in Texas [this state], regardless of where the certificate holder, policyholder, insurer, or agent is located, must be on a form that has been filed and approved before [prior to] use.

(b) Filing content. All filings for new or amended certificate of insurance forms submitted under [pursuant to] Insurance Code Chapter 1811 must comply with the filing requirements [set forth] in this division, any other applicable rules the Commissioner [commissioner] has adopted, and any applicable Commissioner's [commissioner's] orders.

(1) All filings must contain transmittal information as required by §5.9373 of this title (relating to Certificate of Insurance Form Filing Transmittal Information).

(2) All filings must contain a copy of the subject certificate of insurance form. For identification purposes, the certificate of insurance must contain a form number and edition date.

(c) Combined filings. Do not combine a certificate of insurance form filing with any other filing types.

(d) Filing submission.

(1) TDI will accept a filing required under this division by mail. Send filings to the Texas Department of Insurance, Property and Casualty Filings Intake, Mail Code 104-3B, P.O. Box 149104, Austin, Texas 78714-9104.

(2) TDI will accept a filing required under this division if it is hand delivered.[hand-delivered.] Bring filings to the Texas Department of Insurance, Customer Service Center, William P. Hobby Jr. State Office Building, 333 Guadalupe St., Tower 1, Room 103, Austin, Texas 78701.

(3) TDI will accept a filing required under this division that is submitted electronically, whether by email to PCFilingsIntake@tdi.texas.gov or through SERFF.

(4) TDI will not collect a filing fee for a certificate of insurance filing.

(e) Public inspection of filing.

(1) A certificate of insurance form and any supporting information filed with TDI under this division is open to public inspection as of the date of the filing.

(2) To the extent that a filing includes company contact information, the company affirmatively consents to the release and disclosure of its company contact information, including any email addresses.

§5.9373. Certificate of Insurance Form Filing Transmittal Information.

(a) Required information. The filing transmittal information must be typed and must contain, at a minimum, the following:

(1) company name;

(2) NAIC number if the filing is submitted by an insurer;

(3) FEIN if the filing is submitted by an entity other than an insurer or agent; and

(4) contact person, including name, telephone number, mailing address, fax number, and email address (if available).

(b) Transmittal information format.

(1) The Certificate of Insurance Form Filing Transmittal Form is available on TDI's website at www.tdi.texas.gov or by request to the Texas Department of Insurance, Property and Casualty Filings Intake, Mail Code 104-3B, P.O. Box 149104, Austin, Texas 78714-9104.

(2) Filers may submit transmittal information in a format other than the form provided by TDI if the information included in the transmittal form, or in an addendum to the transmittal form, contains all the information required under subsection (a) of this section.

(c) SERFF filings. Persons filing through SERFF must follow existing procedures for SERFF filings.

§5.9374. Incomplete Filings.

(a) A filing is incomplete if the filing does not comply with all of the filing requirements described in this division.

(b) TDI will inform a [return an incomplete filing to the] filer with a letter or electronic notification indicating the reasons why a filing is incomplete. [for the return.]

(c) The 60-day period in Insurance Code §1811.101(c) does not commence until TDI receives a complete filing.

§5.9376. Restrictions on the Content of Certificates of Insurance.

(a) Required language. A certificate of insurance must contain the phrase "for information purposes only" or similar language, or state that:

(1) the certificate of insurance does not confer any rights or obligations other than the rights and obligations conveyed by the policy referenced on the form; and

(2) the terms of the policy control over the terms of the certificate of insurance.

(b) Specific limitations.

(1) A certificate of insurance may not amend, extend, or alter the coverage afforded by the referenced insurance policy.

(2) A certificate of insurance may not confer to a certificate holder new or additional rights beyond what the referenced policy or any executed endorsement provides.

(3) A certificate of insurance may not alter or modify a certificate of insurance form approved by TDI unless TDI approves the alteration or modification.

(4) A certificate of insurance may not contain false or misleading information concerning the referenced insurance policy.

(A) Requests for information on the certificate of insurance form must be specific, clear, and reasonable.

(B) Any explanatory information included in a completed certificate of insurance is limited to language in the referenced policy and any executed endorsements.

(5) A certificate of insurance may not contain a reference to a legal or insurance requirement contained in a contract other than the

underlying contract of insurance, including a contract for construction or services.

(A) A certificate of insurance may refer to the language in the underlying contract of insurance.

(B) A certificate of insurance may not refer to, describe, explain, or define obligations under a contract other than the underlying contract of insurance.

(6) A certificate of insurance may not alter the terms and conditions of a right to notice of cancellation, nonrenewal, or material change, or any similar notice concerning a policy of insurance required by the insurance policy or Texas law.

(A) A certificate of insurance may not create a new or additional duty to notify.

(B) Any statement on a certificate of insurance regarding an existing duty to notify is limited to language in the referenced policy and any executed endorsements.

(c) Disapproval. The Commissioner [~~commissioner~~] will disapprove a filed certificate of insurance form, or withdraw approval of an approved certificate of insurance form if the form:

(1) contains a provision or has a title or heading that is misleading or deceptive or violates public policy;

(2) violates any state law, including an administrative rule;

(3) requires an agent to certify insurance coverage that is not available in the line or type of insurance coverage referenced on the form; or

(4) directly or indirectly requires the Commissioner [~~commissioner~~] to make a coverage determination under a policy of insurance or insurance transaction.

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 December 27, 2018.

TRD-201805578
Norma Garcia
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 676-6584

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 7. DADS ADMINISTRATIVE RESPONSIBILITIES

SUBCHAPTER B. CONTRACTS MANAGEMENT FOR STATE FACILITIES AND CENTRAL OFFICE

40 TAC §7.59

The Texas Health and Human Services Commission (HHSC) proposes the repeal of §7.59, concerning Award of Construction Contracts.

Background and Purpose

Texas Health and Safety Code, §551.007(a) requires the HHSC Executive Commissioner (EC) to design, construct, equip, furnish, and maintain buildings and improvements authorized by law at facilities under HHSC's jurisdiction. Government Code, §531.0055(e), (f)(4), and (j) also tasks the Executive Commissioner with administrative duties of contracting and purchasing and adopting rules necessary to implement these duties. In accordance with these requirements, HHSC has determined the repeal of §7.59 is necessary to provide the procurement of construction contracts in the most fiscally efficient and statutorily compliant manner possible.

HHSC is simultaneously proposing to repeal TAC Title 1, Part 15, Chapter 392, Subchapter E, Contract Management for DSHS Facilities and Central Office to also allow agency consideration of additional procurement methods available for construction contracts instead of one type. These proposed rules will make it unnecessary for agency construction contract bids to be placed in newspapers across the state.

Section-by-Section Summary

Section 7.59 requires HHSC post construction contracts by publishing an invitation for bids (IFB) notice twice in two newspapers of general circulation. HHSC proposes the repeal of §7.59 to reflect the current procurement process of posting construction contracts on the Electronic State Business Daily and through the use of plan rooms. In addition, Government Code, Chapter 2269 governs the various procurement methods available for construction contracts. The current rule restricts the procurement method to only one type. An IFB is not always the appropriate procurement method for construction contracts. The appropriate method should be determined on a case-by-case basis pursuant to Chapter 2269 in order to best meet the business objective and project goals of each procurement.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that, for each year of the first five years that the repealed section is in effect, there may be fiscal implications to state government as a result of enforcing and administering the section as proposed. This rule is expected to provide an estimated $2,500 reduction in cost per construction project, due to the placement of contract bid invitations in newspapers across the state no longer being required. HHSC lacks sufficient data to provide an estimate of the total reduction in costs.

There will be no effect on local government.

Government Growth Impact Statement

In compliance with Government Code, §2001.0221, HHSC has determined that during the first five years the rule is repealed:

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

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

(3) implementation of the proposed repeal will not require an increase or decrease in future legislative appropriations;

(4) the proposed repeal will not affect fees paid to the agency;

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

(6) the proposed action will repeal an existing rule;

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

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

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

Ms. Rymal has determined that there may be an adverse economic effect on small businesses, micro-businesses, or rural communities as the rule is proposed. HHSC will no longer be required to place construction contract bids in newspapers across the state. HHSC lacks sufficient data to determine which newspaper would be considered as a small business, micro-business, or rural community engaged in this service.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the section as proposed.

There is no anticipated negative impact on local employment.

Costs to Regulated Persons

Government Code, §2001.0045 does not apply to this proposal because the proposed repeal does not impose a cost on regulated persons, including another state agency, a special district, or a local government.

Public Benefit

Kay Molina, Associate Commissioner of the Office of Compliance and Quality Control, has determined that for each year of the first five year period the proposed repeal is in effect the public benefit will be a cost savings to HHSC, the ability to use the correct procurement method pursuant to statute, and utilizing the statutorily required posting method already well accepted by the vendor community at issue and freely available to the public.

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 Government Code, §2007.043.

Public Comment

Questions about the content of this proposal may be directed to Kay Molina at (512) 406-2451 in Procurement and Contracting Services.

Written comments on the proposal may be submitted to Kay Molina, Associate Commissioner of Compliance and Quality Control, Procurement and Contracting Services, Texas Health and Human Services Commission, 1100 W. 49th Street, Mail Code 2020, Austin, Texas 78756; or e-mailed to Kay.Molina@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register.*

To be considered, comments must be submitted no later than 30 days after the date of this issue of the *Texas Register.* The last day to submit comments falls on a Sunday; therefore, 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) e-mailed by midnight on the last day of the comment period. When e-mailing comments, please indicate "Comments on Proposed Rule 19R013" in the subject line.

ADDITIONAL INFORMATION

For further information, please call: (512) 406-2451.

Statutory Authority

The repeal is proposed under Government Code §531.0055(e) and §531.033 and Health and Safety Code §551.006(a) which provides the Executive Commissioner of HHSC with rulemaking authority.

The statutory provisions affected by the proposed rules are those set forth in Government Code, §531.00553, Government Code Chapter 2269, and Health and Safety Code §551.007.

§7.59. Award of Construction Contracts.

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 December 21, 2018.

TRD-201805563
Karen Ray
Chief Counsel
Department of Aging and Disability Services
Earliest possible date of adoption: February 10, 2019
For further information, please call: (512) 406-2451

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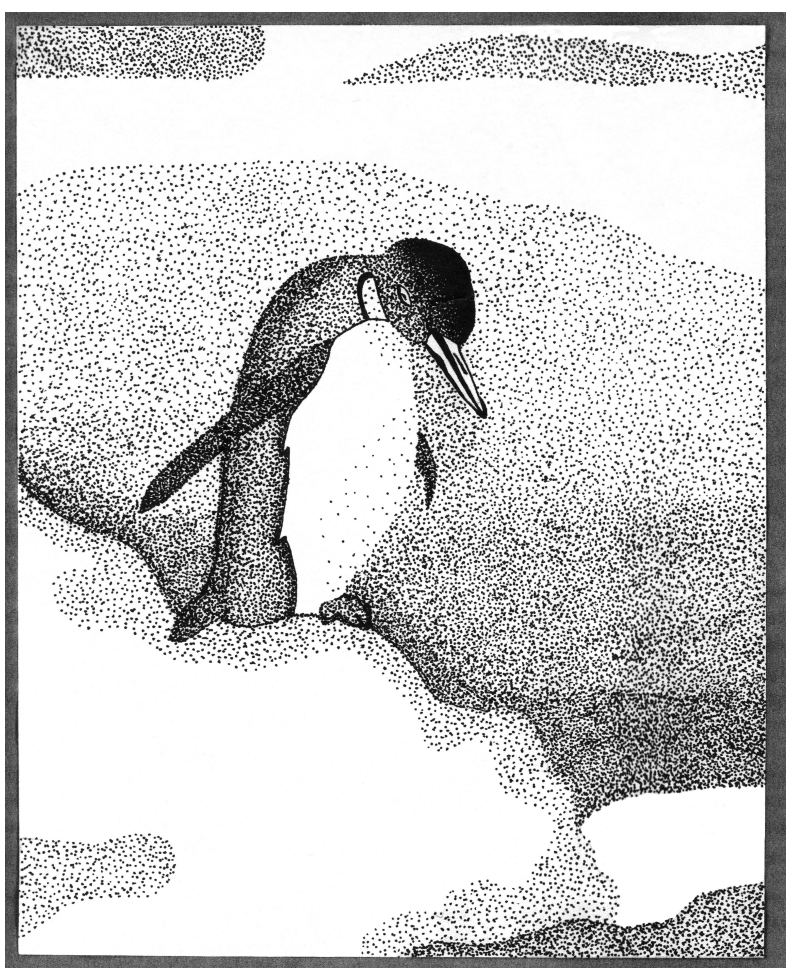

ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

The Texas Health and Human Services Commission (HHSC) adopts the repeal of §351.9, concerning Public Complaints, in Title 1, Part 15, Chapter 351, Subchapter A, concerning General Provisions, of the Texas Administrative Code (TAC) as published in the June 22, 2018, issue of the *Texas Register* (43 TexReg 3957). HHSC also adopts the repeal of §§351.861, 351.863, 351.865, 351.867, 351.869, 351.871, 351.873, 351.875, 351.877, 351.879, 351.881, 351.883 in Title 1, Part 15, Chapter 351, Subchapter B, Division 2, concerning Ombudsman for Children and Youth in Foster Care, of the TAC as published in the June 22, 2018, issue of the *Texas Register* (43 TexReg 3957).

BACKGROUND AND JUSTIFICATION

The repeal of §351.9 is to remove outdated information regarding the Office of the Ombudsman (OO) and to provide new rules for further expansion and clarification based on OO's legislative authority and jurisdiction. Since adoption of the rule, OO was reauthorized by Senate Bill 200, 84th Legislature, Regular Session, 2015.

The repeal of Chapter 351, Subchapter B, Division 2, is to relocate and amend the rules to reflect passage of House Bill 5, 85th Legislature, Regular Session, 2017. The new rules relating to OO are being adopted in TAC Title 26, Health and Human Services, Part 1, Health and Human Services Commission, new Chapter 87, Ombudsman Services, Subchapters A, B, C, and D, in this issue of the *Texas Register.*

COMMENTS

The 30-day comment period ended July 22, 2018.

During this period, HHSC did not receive any comments regarding the proposed repeals.

ADDITIONAL INFORMATION

For further information, please call: (512) 706-7120.

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §351.9

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0171, Office of Ombudsman, which establishes the HHS Executive Commissioner's (EC) authority and responsibility over the HHS Ombudsman functions; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830, 84th Legislature, Regular Session, 2015, which establishes HHS OO FCO responsibility to develop and implement statewide procedures regarding, among other areas, complaints involving children and youth in the conservatorship of DFPS; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHS EC shall adopt rules for the operation and provision of services by the health and human services agencies.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805559
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

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SUBCHAPTER B. ADVISORY COMMITTEES

1 TAC §§351.861, 351.863, 351.865, 351.867, 351.869, 351.871, 351.873, 351.875, 351.877, 351.879, 351.881, 351.883,

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0171, Office of Ombudsman, which establishes the HHS Executive Commissioner's (EC) authority and responsibility over the HHS Ombudsman functions; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830, 84th Legislature, Regular Session, 2015, which establishes HHS OO FCO responsibility to develop and implement statewide procedures regarding, among other areas, complaints involving children and youth in the conservatorship of DFPS; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHS EC shall adopt rules for the operation and provision of services by the health and human services agencies.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805560
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

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CHAPTER 355. REIMBURSEMENT RATES
SUBCHAPTER J. PURCHASED HEALTH SERVICES

The Texas Health and Human Services Commission (HHSC) adopts new §355.8208, concerning Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care; §355.8210, concerning Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care; §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care; and §355.8214, concerning Waiver Payments to Physician Group Practices for Uncompensated Charity Care. Sections 355.8208, 355.8210, 355.8212, and 355.8214 are adopted with changes to the proposed text as published in the July 27, 2018, issue of the *Texas Register* (43 TexReg 4907). The texts of those rules will be republished.

HHSC also adopts amendments to §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care, §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services; and §355.8600, concerning Reimbursement Methodology for Ambulance Services. Sections 355.8202, 355.8441, 355.8600 are adopted without changes to the proposed text as published in the July 27, 2018, issue of the *Texas Register* (43 TexReg 4907), and therefore will not be republished.

The July 27, 2018, issue of the *Texas Register* included the proposed amendment to §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care. However, that proposed amendment was withdrawn in the September 21, 2018, issue of the *Texas Register* (43 TexReg 6239). A new proposal with an amendment to §355.8201 was subsequently published in the September 21, 2018, issue of the *Texas Register* (43 TexReg 6043), and the adoption was published in the November 16, 2018, issue of the *Texas Register* (43 TexReg 7519). Section 355.8201 became effective on November 26, 2018.

BACKGROUND AND JUSTIFICATION

The new rules and amendments are necessary to implement revised definitions of eligible uncompensated costs and funding requirements contained in the state's approved Section 1115(a) waiver extension and to implement other policy changes.

COMMENTS

The 60-day comment period ended September 25, 2018.

During this period, HHSC received comments regarding the proposed rules from 56 commenters, including:

Addison Fire Department

Baptist Hospitals of Southeast Texas

Bedford Fire Department

BKD, L.L.P.

Bryan Fire Department

BSA Health System

Calhoun County EMS

Carrollton Fire Rescue

Cedar Hill Fire Department

Children's Hospital Association of Texas (CHAT)

CHRISTUS Health

Community Health Systems (CHS)

City of Lewisville Fire Department

City of Midland Fire Department

City of New Braunfels

Coalition for Nurses in Advanced Practice

Community Health Systems

Coppell Fire Department

Corpus Christi Fire Department

Dallas County Fire Chief's Association

Dawson County Hospital District, Medical Arts Hospital

Denison Fire Rescue

Dimmit Regional Hospital

Duncanville Fire Department

Farmers Branch Fire Department

Garland Fire Department

Glenn Heights Fire Department

Golden Plains Community Hospital

Grand Prairie Fire Department

Grapevine Fire Department

Harris Health System

Hemphill County Hospital District

Keller Fire Rescue

Kerrville Fire and EMS

La Salle Fire Rescue

Laredo Fire Department

LifePoint Health

Longview Fire Department

Mangold Memorial Hospital

Marshall Fire Department

Mesquite Fire Department

Midland Health

North Richland Hills Fire-Rescue

Parkland Health & Hospital System

Pearland Fire Department

Plano Fire-Rescue Support Services

Sherman Fire Department

Texas Essential Hospital Partnership (TEHP)

Texas Hospital Association (THA)

Teaching Hospitals of Texas (THOT)

Texas Organization of Rural and Community Hospitals (TORCH)

Universal Health Services, Inc.

University Medical Center Health System

Wilmer Fire Department

A summary of comments relating to the rules and HHSC's responses to the comments follow.

Comments Related to Amendments to §355.8441, §355.8600, and §355.8202

HHSC did not receive any comments to the proposed amendments to §355.8441, concerning Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services; §355.8600, concerning Reimbursement Methodology for Ambulance Services; and §355.8202, concerning Waiver Payments to Physician Group Practices for Uncompensated Care. The amendments are adopted without changes to the proposed text.

Comments Related to New §355.8208, §355.8210, §355.8212, and §355.8214

Transitioning to Charity-Care Costs

Comment: Several commenters suggested that HHSC reconsider the exclusion of Medicaid shortfalls and non-Medicare bad debt in the definition of eligible uncompensated care (UC) costs. The commenters urged HHSC to reopen waiver negotiations with the federal Centers for Medicare & Medicaid Services (CMS) and provide for a transition period to allow hospitals to prepare for the use of S-10 data exclusively.

Response: HHSC had extensive and lengthy negotiations with CMS on the terms of the renewed waiver and fought for continuing to reimburse non-charity-uninsured costs and Medicaid shortfall through UC pool payments. CMS would not agree and conditioned approval of the waiver renewal on, for one thing, limiting eligible costs to those incurred for providing care consistent with providers' charity-care policies. CMS initially proposed applying the limitation in Demonstration Year (DY) 8, which corresponds with the federal fiscal year that began on October 1, 2018, but was persuaded by HHSC to delay implementation of the policy until DY 9. CMS considers DYs 7 and 8 to be the transition period during which the state and stakeholders would make the necessary adjustments to charity-only costs. For these reasons, HHSC does not believe reopening discussions with CMS on this issue would be successful. The rule was not changed in response to this comment.

Comment: If there is not going to be a transition period for hospitals to adjust to the proposed rule, then one commenter requested a chance to adjust charity care reported on CMS Worksheet S-10 and on Schedule 3 of the UC Tool application to reflect current year charity care write-offs instead of cost report data that is two years old.

Response: Consistent with federal requirements for amending S-10 reported data, hospitals can submit revised S-10 worksheets for the data year to their Medicare Administrative Contractors (MACs) before the data will be collected and used in calculation of hospitals' DY 9 UC payments. Additionally, §355.8212(g)(5) as proposed authorizes a hospital to request adjustments to costs not reflected on the as-filed cost report but which would be incurred for the DY, as long as the request is accompanied by supporting documentation. Since hospitals have the opportunity through these means to adjust charity-care costs originally reported on the S-10, the rule was not amended in response to this comment.

Comment: Multiple commenters suggested that HHSC develop a transition plan to ease hospitals into the new rates with floors and ceilings to protect various classes.

Response: HHSC understands the commenters to be proposing limits on increases and decreases to the percentage or amount of the UC pool that a class of hospitals will receive relative to prior demonstration years. CMS will not allow HHSC to pay hospitals for costs that their charity care volume will not support, regardless of prior year payment amounts. Consequently, HHSC cannot guarantee that UC payments to a class of hospital will not drop below a given amount or percentage if the hospitals' reported charity-care costs cannot support those payments. HHSC has attempted to model significant shifts in funding among classes of hospital that may occur with the transition to charity-only costs and to propose policies in this rule to mitigate those shifts. HHSC will monitor the charity-care cost data as it becomes available to determine whether the policies should be reevaluated in the future. The rule was not changed in response to these comments.

Comment: One commenter recommended that schedule S-10 should be audited by Medicare before being used to allocate the UC pool, in order to avoid errors and the possibility of fraud. Another commenter urged HHSC to employ a contractor to audit S-10 data prior to making payments.

Response: The S-10 data that is used to allocate UC funds and calculate individual hospital UC payments is taken from the Healthcare Cost Reporting Information System (HCRIS) database for the cost reporting period two years before the demonstration year. MACs do audit the cost reports, but those audits may not always be completed when HHSC needs the data to calculate UC payments. HHSC cannot require the MAC to audit the S-10 data by a certain date and cannot delay payment calculations until all S-10s have been fully audited by them. Additionally, the time and cost to the state of performing audits of S-10 data prior to using the information for resizing and distribution of UC payments would be prohibitive. For these reasons, HHSC will use the most recent cost report and S-10 data available on HCRIS, whether it has gone through audit or not. The rule was not changed in response to this comment.

Non-hospital pool allocations

Comment: Multiple ambulance providers objected to the proposed limitation on the amount of the ambulance provider pool in DY 9 and after that was proposed in §355.8212(f)(2). Commenters allege that the amount of UC payments in DY 6 that limits the DY 9 pool will grossly underrepresent the amount of actual charity-care costs that ambulance providers will incur in

DY 9 and after and that the policy is unreasonable, arbitrary and potentially capricious. Commenters proposed that ambulance providers receive the same percentage of reported charity-care costs as hospitals receive.

Response: HHSC disagrees that the policy articulated in the rule is unreasonable, arbitrary, or capricious. Although HHSC fought to include the charity-care costs of all UC providers in pool resizing, CMS was unwilling to compromise on that point because, according to CMS, they are moving to the same basis for allowable costs in all states that have UC pools. Consequently, the size of the pool is determined by charity-care costs incurred by hospitals alone. Hospital stakeholders are concerned about the potential for growth of non-hospital charity-care costs that dilute the ability of the hospitals to recover their uncompensated costs that went into pool sizing, which hospitals believe is justified based on the growth of the ambulance providers' percentage of the UC pool between DY 1 and DY 6.

The policy proposed in the rule strikes a balance between the interests of the hospital and non-hospital providers: it ensures that as long as reported charity-care costs of non-hospital providers can support the same percentage of reimbursement in the aggregate they received in DY 6, they continue to receive that level of reimbursement (which may result in ambulance providers receiving a higher percentage of their eligible costs than do hospital providers). The policy also ensures that hospital providers will not continue to see dilution in their ability to recover their uncompensated charity-care costs from a limited UC pool amount. The rule was not changed in response to this comment.

Comment: HHSC received multiple comments recommending that HHSC remove the special protection proposed in §355.8212(f)(2) that guarantees non-hospital providers receive at least what they received in DY 6, unrelated to charity-care costs. Commenters argued that setting aside a portion of the statewide UC pool for non-hospital providers contradicts CMS direction to use UC funding to support charity care provided by safety-net hospitals. Commenters also stated that any portion of the UC pool paid to non-hospital providers will reduce the UC funding available for hospitals whose charity costs determined the size of the UC pool.

Response: HHSC disagrees that the proposed rule guarantees non-hospital providers a share of the pool that is unrelated to charity-care services they provide. Like hospitals, non-hospital UC providers can only receive reimbursement from the UC pool for costs incurred for services provided to individuals eligible for charity care under the provider's charity care policy. Consequently, even in DY 9, these providers (individually and in the aggregate) are not guaranteed to receive the same percentage of the UC pool they received in DY 6 unless they can support that amount through documented charity-care costs.

HHSC also disagrees that payment to these providers contradicts CMS' direction in the terms of the waiver because those terms expressly authorize reimbursement to these non-hospital providers. HHSC understands the concern that CMS will only allow hospital charity-care costs to be considered in determining pool size and payments to non-hospital providers reduce the ability of hospitals to be reimbursed for those costs. However, HHSC believes the proposed rule articulates a balanced policy and provides HHSC with the broadest discretion to adjust the amount of funding flowing to non-hospital providers in the future, when there is actual data available to determine the amount of charity care cost incurred by non-hospital providers. The rule was not changed in response to this comment.

Comment: Multiple commenters proposed revising §355.8212(f)(2) to limit the amount of funding for non-hospital provider pools in DY 9 and after to the lesser of an amount equal to the percentage of the applicable total uncompensated-care pool amount paid to each group in DY 6 or the amount of charity care reported by the non-hospital providers in each pool in the respective DY. Commenters stated capping these pools would preclude unfettered growth of non-hospital costs and align payment rules for hospital and non-hospital providers.

Response: Like hospitals, non-hospital UC providers can only receive reimbursement from the UC pool for costs incurred for services provided to individuals eligible for charity care under the provider's charity care policy and reported on the non-hospital provider applications. However, unlike hospitals, the reported costs for government dental and government ambulance providers are not known for a year after the UC funds are "allocated" among the pools. Ambulance and dental providers report actual costs following the end of the demonstration year (as opposed to relying on proxy costs from the data year, as hospital and physician groups do). Also, HHSC does not have historical data on non-hospital charity-care costs to enable the agency to estimate the costs that will be reported on non-hospital applications in DY 9. Therefore, when the total UC pool is allocated prior to making hospital and physician group payments in DY 9, the policy proposed in the rule balances the interests of non-hospital providers and hospitals in that it (1) ensures that non-hospital providers have continued access to UC funds at an historical level if they have the charity-care costs to support payments at that level; and (2) protects hospitals from reductions to their UC payments should non-hospital eligible costs for DY 9 be greater than total UC payments to non-hospital providers in DY 6. For DY 10 and after, HHSC will have non-hospital charity-care data to inform allocation decisions for those years. The rule was not changed in response to this comment.

Non-state-owned hospital pool allocation

Comment: Multiple commenters asked for clarification in §355.8212 about whether funding in the non-state-owned hospital pool is allocated to the Medicaid service-delivery-area (SDA) sub-pools or to individual non-state-owned hospitals.

Response: HHSC agrees that the rule would be improved by clarifying that allocations of funds within the non-state-owned hospital pool is done on an individual hospital basis, using the revised maximum payment amounts calculated for each non-state-owned hospital. Changes were made from the proposed version to subsections (b)(2) (defining "allocation amount"); (f)(1) and (2) (relating to funding limitations); and (g)(6) (relating to reductions to stay within UC pool allocation amounts).

Separate sub-pools for certain hospital classes

Comment: One commenter proposed amending §355.8212 to create additional sub-pools within an SDA for "public" and "private" hospitals. The commenter argued that public hospitals would benefit under the proposed methodology at the expense of private hospitals. Other commenters proposed creating separate sub-pools for hospitals that provide a significant amount of uncompensated charity care, or for "DSH providers" versus "non-DSH providers," or otherwise based on hospital class (e.g., large public hospitals). The commenters stated that these hospitals are pillars of the safety-net community and preferential treatment is necessary to ensure their stability. Still other commenters wrote to oppose further subdivisions within the SDA sub-pools.

Response: The terms of the waiver require that distribution of UC funds be unrelated to the source of the non-federal share, creating the potential for "free riders" (i.e., providers that do not have a source of funds for the non-federal share but that are eligible for a UC payment). The goal of the proposed policy grouping all classes of hospital into SDA sub-pools was to take advantage of existing regional funding relationships established for other hospital reimbursement programs (like the Uniform Hospital Rate Increase Program) to facilitate local communication and cooperation to more effectively address a free-rider problem on a local level, should it occur.

Further dividing SDA sub-pools by hospital class or ownership type would insulate certain hospitals from the effects of insufficient funding of the non-federal share of UC payments. While protecting the stability of safety-net hospitals is an important goal, HHSC believes creating additional sub-pools may dilute the incentive for all of the hospitals and governmental entities in the SDA to work together to ensure full funding for UC payments. Further dividing sub-pools may also create disparities among hospital classes in which some classes are fully funded and others are not. For these reasons, the rule was not changed in response to these comments.

Healthcare Financial Management Association (HFMA) principles

Comment: Some commenters suggested that the reference to the HFMA principles in the definition of "charity care" in each of the proposed new rules should be date specific, since the guidelines could be revised and the principles against which providers may be audited should be clear.

Response: HHSC agrees with the commenter. The definition of "charity care" in each of the proposed new rules was revised to clarify that "[t]he charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2012)."

Comment: Some ambulance providers object to the requirement that all providers' charity-care policies must adhere to the principles of the HFMA. According to the commenters, the HFMA guidelines are expressly intended for institutional providers; complying with them is not feasible for ambulance providers because having a financial discussion will interfere with patient care and disrupt patient flow; and having financial discussions in the circumstances where ambulance providers are interacting with patients could violate patient privacy. Additionally, ambulance providers do not employ financial counselors or patient representatives to conduct the charity-care discussions, which is recommended by HFMA. Commenters state that ambulance providers should not be subject to the same rules and regulations as institutional providers.

Response: HHSC recognizes that the HFMA guidelines were not intended to apply to non-institutional providers. However, CMS is unwilling to excuse non-hospital providers from compliance with the guidelines. Consequently, HHSC does not have discretion to excuse non-hospital providers from the requirements in the Special Terms and Conditions (STCs) without risking a loss of federal matching funds for payments to these providers.

The HFMA guidelines provide for flexibility in the development of charity-care policies and, to a certain extent, the methods for determining financial status of individuals transported by ambulance providers. HHSC encourages providers to work collaboratively to identify policies and procedures that comply with the guidelines while recognizing the limitations on questioning patients in compliance with the HFMA guidelines as well as state and federal laws. The rule was not changed in response to these comments.

Definition of "Rural Hospital"

Comment: Some commenters noticed that there is a one word difference between the definitions of "rural hospital" in §355.8201, concerning Waiver Payments to Hospitals for Uncompensated Care, and the proposed §355.8212. The commenter recommended that, to be consistent, HHSC add the word "or" in the §355.8212(b)(19)(A).

Response: HHSC agrees with the commenter. The word "or" should be included to be consistent with the definition in §355.8201 and to avoid confusion that a rural hospital may be any of the three types listed. HHSC has revised §355.8212(b)(19) from the proposed version to add "or" at the end of subparagraph (A).

Comment: Multiple commenters recommended revising §355.8212(b)(19)(C) to clarify whether the limitation to "100 beds" refers to "staffed beds" or to "licensed beds." Commenters explained that hospitals frequently staff a lower number of beds in their hospitals than they are licensed for and suggested those providers should be considered "rural" if their licensed bed count exceeds 100 but they staff fewer beds.

Response: HHSC uses "licensed" beds for determining a hospital's designation as rural for inpatient and outpatient reimbursement. Using "staffed" beds in the UC program would create inconsistencies between hospitals' designation among Medicaid payment programs. It would also create a situation where a hospital would be rural in UC one year and non-rural the next year, if the hospital increased its staffed bed count. These inconsistencies weigh against using "staffed" beds. HHSC does believe the rule would be improved by clarifying the definition of rural hospital. Therefore, §355.8212(b)(19)(C) has been modified from the proposed version to specify that a rural hospital can meet any of three criteria, including being designated by Medicare as a Rural Referral Center (RRC) located in a Metropolitan Statistical Area (MSA) with 100 or fewer licensed beds.

Rural Hospital Reimbursement

Comment: Multiple commenters supported the proposed definition of "rural hospital" in §355.8212.

Response: HHSC appreciates the comment. The rule was not changed in response to this comment.

Comment: Multiple commenters objected to the policy articulated in §355.8212(g)(6)(D)(ii)(I) limiting rural hospital reimbursement in DY 10 and after to the amount set aside for rural hospitals in DY 9 and urged HHSC to remove it and allow rural hospitals to continue receiving 100% of their maximum annual payment amounts after DY 9. Commenters argued that the limitation acts as an unnecessary obstacle to potential increases in uncompensated care costs faced by rural hospitals in DY10 and DY11. They stated that true rural hospitals need protection in their UC payments because they are more dependent on supplemental payments to address their shortfall for services to the low-income community than urban hospitals or hospitals that are part of a larger system.

Response: HHSC disagrees with the commenters that the policy creates an obstacle to potential increases in UC costs faced by rural hospitals because even if rural hospitals see some in-

creases in charity-care costs relative to DY 9, it is likely that they will continue to be reimbursed a higher percentage of those costs through the UC program than are non-rural hospitals. So, it does not disadvantage rural hospitals to capture and report all of their eligible charity care costs after DY 9. HHSC believes the policy articulated in the rule balances the goals of protecting the financially vulnerable rural safety-net hospitals while preventing significant shifts in funding away from non-rural hospitals in DYs 10 and after. The rule was not changed in response to these comments. However, HHSC will monitor the costs reported by rural hospitals on the applications for future UC periods to determine whether the policy should be revisited.

Comment: Some commenters recommended that HHSC not lock in a percentage of UC payments as preferential treatment for rural hospitals or other hospital classes until the 2017 Medicare Cost report data are available and the pool size amount is known.

Response: The terms of the waiver provide a penalty to the state in the form of a 20% reduction in the amount of UC funds for DY 8 if the state fails, by January 31, 2019, to adopt the rules describing the UC payment methodology for DY 9. The 2017 cost report data and DY 9 pool size will not be known prior to that deadline. Consequently, HHSC cannot wait for that information before adopting the rule. However, when the 2017 cost report data becomes available, should it indicate that protection for rural hospitals at the level proposed is unnecessary or inequitable, HHSC will consider reopening the rule to revise the policy to achieve a more equitable result. The rule was not changed in response to this comment.

Comment: Multiple commenters recommended that HHSC remove the rural hospital protection altogether or have guardrails to prevent further shifts of funding away from non-rural to rural hospitals.

Response: HHSC does not agree that the rural hospital protection should be removed. Historically, HHSC provided preferential treatment to rural hospitals in the UC program by making a rural hospital's UC payment equal to a particular percentage of that hospital's eligible uncompensated costs. The original intent behind this policy was provided in the June 27, 2014, issue of the *Texas Register* (39 TexReg 4844) which stated that it was to provide "a certain level of protection in UC in recognition of the financial vulnerability of [rural] hospitals and the critical role they play in preserving the rural safety net."

Based on modeling that has been performed to estimate the flow of UC funds beginning in DY 9, rural hospitals will likely see a significant reduction in UC payments due to the transition to charity-only costs. Consequently, the need for protecting these financially vulnerable providers remains. Proposed §355.8212 gives preferential treatment to rural hospitals in the form of reimbursing them 100% of their maximum annual UC payment amounts in DY 9. In recognition of the interests of non-rural hospitals, HHSC also proposed a "guardrail" that will limit the amount of available funds for rural hospitals in DY 10 and after to the percentage of the pool they received in the aggregate in DY 9. HHSC believes this policy balances the goals of protecting the financially vulnerable rural safety-net hospitals while preventing unexpected shifts in funding away from non-rural hospitals in DY 10 and after. The rule was not changed in response to these comments.

Comment: Some commenters support the policy limiting rural hospital reimbursement in DY 10 and after to the aggregate amount paid to rural hospitals in DY 9, but asked HHSC to also apply a limitation on increased payments on an individual hospital basis. The commenters suggested that each individual rural hospital could be limited to the lesser of its actual eligible costs from the data year or 110% of the amount the hospital received in DY 9.

Response: HHSC appreciates the support of the policy articulated in the proposed rule, but declines at this time to further limit eligible costs for rural hospitals on an individual provider basis. HHSC does not want to adopt a policy that may discourage any hospital from expanding the provision of charity care. Additionally, significant increases in eligible charity-care costs for some rural hospitals may be completely outside of the control of the entity (such as the closure of a near-by hospital or an unusual health-care crisis in a community), and HHSC does not want to penalize a hospital that provides charity-care under those circumstances. For these reasons, the rule was not changed in response to this comment. HHSC will monitor the costs reported by rural hospitals on the applications for future UC periods to determine whether the policy should be revisited.

Comment: One commenter proposed to allow rural hospitals to opt out of being treated as rural in the event that eligible costs for other rural hospitals increase so significantly that rural hospitals are receiving a lower percentage of eligible costs than are non-rural hospitals.

Response: Based on modeling performed to estimate the flow of UC funds beginning in DY 9, it appears unlikely that rural hospital charity-care costs will increase so significantly in 2018 and 2019 that rural hospitals will be reimbursed a lower percentage of eligible costs than non-rural hospitals in DYs 10 and 11. HHSC declines to adopt a policy based on an event that is unlikely to occur. The rule was not changed in response to this comment.

Disproportionate Share Hospital (DSH) Intergovernmental Transfer (IGT) Credit for public hospitals

Comment: Multiple commenters supported the proposal in §355.8212 that the amount transferred by large public hospitals to HHSC to support DSH payments is included the calculation of those hospitals' annual maximum uncompensated care payment.

Response: HHSC appreciates the comment. The rule was not changed in response to this comment.

Comment: One commenter requested clarification in §355.8212(g)(2)(A)(iv) to clarify that the amount of the DSH IGT credit given to large public hospitals includes the amount of transferred to support DSH payments for both the public hospital and private hospitals.

Response: HHSC agrees that the rule would be improved by adding the language suggested by the commenter. HHSC amended §355.8212(g)(2)(A)(iv) to clarify that it is the amount transferred to HHSC for DSH payments to the large public hospitals and to private hospitals.

Comment: Multiple commenters recommended that the rule be changed to allow the amount transferred by all non-rural public hospitals to HHSC to support DSH payments be included in the calculation of their annual maximum UC payments. The commenters suggest that unless they receive credit for their DSH funding, these hospitals are penalized in their UC payment in the amount of the funds transferred for DSH.

Response: HHSC disagrees that small public hospitals are penalized if they do not receive credit for their DSH IGTs. The

rationale for giving DSH IGT credit to large public hospitals is to recognize their funding of DSH payments to private hospitals and to incentivize them to continue funding private hospitals in the DSH program. The funds transferred to HHSC by other public hospitals for DSH benefit only those hospitals; they do not contribute to the non-federal share of private hospitals' DSH payments. HHSC will monitor UC payments to small public hospitals in the future to determine whether there is a need to reevaluate the policy. The rule was not changed in response to these comments.

Comment: Multiple commenters requested HHSC to remove DSH IGT Credit for Large Public Hospitals proposed in §355.8212(g)(2). The commenters argued that the Large Public Hospitals' IGTs for the Medicaid DSH program have no relation to their costs for charity care to uninsured patients, making the proposed methodology inconsistent with CMS direction that the new UC methodology direct funding based on charity care. Additionally, the commenters argued, directing additional UC payments to Large Public Hospitals based on their IGTs for the DSH program appears inconsistent with the separate CMS requirement that prohibits any correlation between the amount of UC payments to individual providers and the amount of their IGTs to HHSC.

Response: HHSC disagrees with the commenters. Giving the Large Public Hospitals credit for their support of the DSH program is not inconsistent with any terms of the CMS-approved waiver. No UC hospital, including a Large Public Hospital, can be paid more than its total charity-care costs reported on the S-10 and other eligible charity-care costs for physician and pharmacy services, so the payments are not violative of the requirement that UC payments reimburse hospitals based on charity care. Also, UC payments to all hospitals, including the Large Public Hospitals, are unrelated to the source of the non-federal share of those UC payments. The rule was not changed in response to this comment.

Comment: Several commenters requested that HHSC amend §355.8212 to reduce the DSH IGT credit for large public hospitals. The commenters argued that the amount of the credit exceeds the amount needed to incentivize the large public hospitals to continue funding DSH, to the disadvantage of other hospitals. Some of these commenters proposed limiting the DSH IGT credit to the amount that is attributable to uninsured charity care using the same ratios as the calculation of the DSH payments attributable to uninsured charity care.

Response: Preliminary modeling of the methodology proposed by these commenters suggests that for some of the large public hospitals, they would receive no DSH IGT credit at all because their DSH payments are completely absorbed by their Medicaid shortfall, leaving the amount of the DSH payment attributable to uninsured charity-care at zero. Reducing the IGT credit by any amount, and especially to zero, would attenuate the goal of incentivizing these public entities to continue funding private hospitals in the DSH program. However, as with other issues discussed in this document, modeling will be updated over the coming months. Should updated modeling indicate that giving full credit to the large public hospitals for their DSH IGT amounts is inequitable or unnecessary to incentivize their continued funding of private hospitals in DSH, HHSC will consider revising this policy. The rule was not changed in response to these comments.

DSH payment offset

Comment: Two commenters asked HHSC to remove the Medicaid DSH Payment Offset described in §355.8212(g)(2)(A). The commenters state that adding a DSH offset to the UC payment pool methodology is duplicative with §355.8212(g)(2)(B), which provides that a hospital cannot receive total UC payments and DSH payments that exceed the hospital's total eligible uncompensated costs. According to the commenters, adding a separate DSH Offset to the calculation of a hospital's uninsured charity costs will artificially reduce UC funding for DSH hospitals beyond the amount needed to ensure they aren't paid over their total uncompensated costs, penalizing hospitals that participate in the DSH program.

Response: HHSC disagrees with the commenter that the DSH offset described in §355.8212(g)(2)(A) is duplicative with §355.8212(g)(2)(B). The DSH offset described in subparagraph (A) ensures compliance with the waiver requirement that a hospital not be reimbursed for the same costs in both DSH and UC. Without the DSH offset, it would be possible for a hospital to receive reimbursement for its uninsured charity-care costs in DSH without exceeding the payment limit described in subparagraph (B). HHSC also disagrees with the commenter that the DSH offset punishes hospitals that participate in both the UC and DSH programs. The DSH-offset process described in the rule is intended to maximize the total amount of available DSH and UC funding by eliminating duplicate payments to any hospital for the same costs, which benefits all hospitals participating in these programs. The rule was not changed in response to this comment.

State-owned hospital reimbursement

Comment: Two commenters asked HHSC to remove the reimbursement priority for state-owned hospitals in §355.8212(f)(2)(A). The commenters expressed an understanding that state-owned hospitals do not report charity care costs in the Medicare Cost Report S-10 worksheets that CMS will use to determine the size of the statewide UC pool and should not be given first priority to DY 9 UC pool funding that was calculated based on the charity costs incurred by other hospitals. The commenters proposed that state-owned hospitals receive UC funding consistent with non-state hospital providers, which is based on their charity care costs and subject to UC pool limitations.

Response: The commenters are incorrect that state-owned hospitals' charity-care costs are not included in determining the size of the DY 9 UC pool. It is true that state-owned Institutions for Mental Diseases (IMDs) and the state-owned cancer hospital, along with children's hospitals and rehabilitation hospitals, are not required to submit the S-10 worksheet with their cost reports. However, the terms of the waiver allow HHSC to capture charity-care costs from those "non-S-10" providers on a CMS-approved cost report and include them in sizing the UC pool. Consequently, state-owned hospitals are not receiving UC payments based on costs incurred by other hospitals. The rule was not changed in response to this comment.

Comment: Two commenters pointed out that under §§355.8212(f)(1)(A) and (g)(2), the amount of the UC pool reserved for state-owned hospitals does not preclude reimbursement for services provided in IMDs to the age 21 through 64 population, even though the current HHSC rules and UC Protocol explicitly disallow costs for services to this population for purposes of UC reimbursement. The commenters recommend that HHSC amend the Proposed Rule to clarify that state-owned IMD hospitals will not receive

additional credit for the cost of services to the age 21 through 64 population under the new UC payment methodology.

Response: HHSC agrees with the commenter that the rule should expressly prohibit reimbursement to an IMD for services to that category of individual. The prohibition applies to all IMDs; not just state-owned facilities. Subsection (g)(3)(B) has been amended from the proposed version to clarify that an IMD may not claim charity-care costs for services to individuals aged 21 through 64.

Schedule 1 and 2 Costs

Comment: Two commenters proposed that HHSC revise §355.8212 to remove the ability of hospitals to claim UC reimbursement for costs arising from physician and mid-level professionals (Schedule 1) and certain pharmacy costs (Schedule 2). Commenters argued that the large public hospitals comprise the majority of the Schedule 1 and 2 costs, which results in a significant shift of UC funds to the hospital class that already receives dramatically more of the UC pool than any other class. According to the commenters, this shift will occur at the expense of hundreds of hospitals that also play a critical role in the hospital safety-net. The commenters urged HHSC to exclude Schedule 1 and 2 costs from the UC calculation, especially if the large public hospitals continue to receive DSH IGT credit in their payments.

Response: The policy to continue reimbursing hospitals for Schedule 1 and 2 costs was included in proposed §355.8212 at the request of numerous hospital stakeholders and hospital associations. Based on that request, HHSC submitted, and CMS approved, a payment protocol that provides for reimbursement of Schedule 1 and 2 costs. The proposed rule is consistent with the protocol and cannot be amended to exclude those costs without also amending the protocol and obtaining CMS approval. Additionally, HHSC has not modeled the impact of removing those costs on all classes of hospital, so information to confirm or contradict the basis of the commenters' request is not available to HHSC or to others at this time. For these reasons, the rule was not changed in response to these comments.

Comment: One commenter asked HHSC to amend the rule to restore clinic costs. The commenter noted that compared to the methodology in place before DY 9, §355.8212(g)(4) no longer expressly includes clinic costs in the definition of "other eligible costs" in the UC payment calculation. The commenter argues that Schedule 1 physician and mid-level professional costs differ from physician clinic costs only with regard to the hospital-professional relationship structure. The commenter urged HHSC to revise §355.8212(g)(4) to clarify that other eligible costs includes physician clinic costs consistent with the UC Protocol and current rules for "other eligible costs."

Response: HHSC disagrees that the proposed removal of the term "clinic" from §355.8212(g)(4) changes the eligible Schedule 1 costs that hospitals are allowed to claim compared to Schedule 1 costs in the previous UC rule. As has always been the case, hospitals may claim direct patient care costs for physicians and mid-levels that occur in a clinic setting as long as those costs are removed in worksheets A-8 and A-8-2. There have never been additional "clinic" costs that were eligible for UC reimbursement. The rule was not changed in response to this comment.

Unused UC Funding

Comment: Should there be UC funds available following the final UC payment for a demonstration year, some commenters proposed revising §355.8212 to allow for a voluntary final pass to all public hospitals that provide a significant share of uninsured and Medicaid care. The commenters suggest this would acknowledge the importance of those hospitals in the safety-net system as partners with the state and as large providers of care, including care to patients who reside outside the counties or districts served by those hospitals. Other commenters opposed giving certain classes of hospital entitlement to the unused funding.

Response: Modeling performed to estimate UC funding beginning in DY 9 suggests that the transition to charity-care costs will benefit large public hospitals more than any other class of provider, so providing an additional opportunity to increase UC reimbursement for those providers does not seem necessary or equitable. Also, since only public hospitals would have access to the proposed final pass, it would benefit hospitals with access to public funds, which may be inconsistent with the waiver requirement that distribution not be related to the source of the non-federal share. For these reasons, the rule was not changed in response to these comments.

Full-Funding Requirement and Termination Provision

Comment: Two commenters asked HHSC to add a full funding requirement and termination provision to §355.8212(c). The commenters note that hospitals are eligible to receive UC payments by entering an affiliation agreement or some other form of enrollment with a government entity, even if that entity has no intention of ever transferring IGT to support UC payments. This would allow "free riders:" hospitals eligible to receive payments from the IGT of any governmental entity in their SDA, reducing the UC payments of every hospital in that SDA. The commenters propose curtailing these unintended consequences by requiring governmental entities, at the time of enrollment, to make legally binding commitments to fully fund their associated hospitals. Alternatively, HHSC could require that the governmental entities pledge to fully fund their enrolled hospitals. Although the pledge would not be legally enforceable against the governmental entity, the hospital's eligibility would automatically terminate if the governmental entity ultimately fails to IGT for its hospitals.

Response: By law, HHSC cannot require a local governmental entity to transfer its public funds to the state to support payments to private providers. Additionally, terminating a hospital from participation in UC for failure of the governmental entity to IGT appears to violate the terms of the waiver prohibiting the state from distributing the pool based on the source of the IGT, meaning a pledge would be unenforceable. Administering the pledge process would also be administratively burdensome. HHSC respectfully declines to implement a pledge requirement at this time. HHSC will monitor the program to determine whether there appears to be a problem with free riders and, if there is, will engage with stakeholders to try to find a solution. The rule was not changed in response to this comment.

Pool Resizing

Comment: One commenter asked HHSC to specify the data year and methodology that will be used for sizing the UC pool in DY 9 and after.

Response: The proposed rules describe the methodology for calculating UC payments to eligible providers; the rules do not address the methodology for resizing the pool, which will be negotiated with CMS pursuant to the terms of the waiver and will be completed prior to the date the methodologies in the rules become effective. The rule was not changed in response to this comment.

Adjustments to charity-care costs

Comment: One commenter recommended revising the proposed rules to more specifically describe the documentation that a provider must submit in support of requested adjustments to reported charity-care costs.

Response: HHSC agrees with this commenter that the rules would be improved by more specific language describing the documentation that must accompany a provider's UC application when changes in costs from the data period are requested. HHSC has revised §355.8212(g)(5)(B) and §355.8214(g)(3)(B) from the proposed version of the rule in response to this comment.

Mid-level professionals

Comment: One commenter asked HHSC to amend §355.8212(b)(15), §355.8212(g)(4)(A)(i), and §355.8214(b)(8) to change the term "mid-level professional" to "non-physician practitioner" and to add clinical nurse specialists (CNSs) to the list.

Response:Both the term "mid-level professional" and the list of practitioners that meet the definition of mid-level professional have been used in the UC program since 2012 and were carried forward when the waiver was renewed. HHSC submitted, and CMS approved, waiver terms and a payment protocol that includes the term and list. The proposed rule is consistent with the protocol and cannot be amended without also amending the protocol and obtaining CMS approval. For this reason, the rule was not changed in response to this comment.

Retroactive Rule

Comment: One commenter stated that proposed §355.8201 and §355.8212 are retroactive rules prohibited by the Texas Constitution.

Response: Although the commenter references §355.8212, this comment appears to be addressing the original proposed amendment to §355.8201 that was published in the July 27, 2018, issue of the *Texas Register* (43 TexReg 4907). The amendment was withdrawn by HHSC in the September 21, 2018, issue of the *Texas Register* (43 TexReg 6239). A new proposal with an amendment to §355.8201 was subsequently published in the September 21, 2018, issue of the *Texas Register* (43 TexReg 6043) and the adoption was published in the November 16, 2018, issue of the *Texas Register* (43 TexReg 7519). The rule became effective on November 26, 2018, to impact payments for DYs 7 and 8. HHSC responded to this same comment in its preamble for that adopted rule and relies on that response regarding §355.8201.

To the extent the comment was intended to apply to §355.8212, this is a new rule and is scheduled to be effective for services provided after October 1, 2019. Consequently, it cannot be said to be retroactive. The rule was not changed in response to this comment.

Rider 38 Hospitals

Comment: Some commenters objected to the definition of "rural hospital" because it excludes large rural referral centers (RRCs) located inside of metropolitan statistical areas. The commenters offered several arguments to support their position that such hospital should receive the preferential treatment provided to rural hospitals in the UC program, including the legislative intent of Rider 38 in the 2013 General Appropriations Act; the federal designation of RRCs as part of the rural safety net; long-term budgeting considerations for these hospitals; and the harm imposed on non-rural RRCs by the last-minute policy changes.

Response: These comments appear to be directed primarily at the change in definition of "Rider 38" hospital or "rural hospital" in §355.8201, which was adopted in the November 16, 2018, issue of the *Texas Register* (43 TexReg 7519) and effective on November 26, 2018, to impact payments for DYs 7 and 8. The same or similar comments were submitted by these commenters during the comment period for that rule and are addressed in the preamble to the adopted rule in the *Texas Register* (43 TexReg 7519). To the extent the comments pertain to the definition of "rural hospital" proposed in §355.8212, HHSC's responses are the same as those provided in response to the comments for §355.8201. This definition is taken from the General Appropriations Act of the 85th Legislature, with the exception of Sole Community Hospitals. The Texas Legislature directed HHSC to give hospitals that meet this definition of "rural hospital" preferential treatment in the context of hospital rates. Streamlining the definition across all hospital payment programs is rational as it allows like hospitals to be treated consistently in each payment program. The rule was not changed in response to these comments.

Compliance with Texas Administrative Procedures Act and Other State Law

Comment: One commenter claims that HHSC violated the Texas Administrative Procedure Act. First, the commenter claims that HHSC violated Texas Government Code §2001.024(4) by failing to provide an analysis of the fiscal impact to the city of Beaumont and Jefferson County. Second, the commenter claims that HHSC violated Government Code §2001.024(5) by failing to provide an analysis of the economic costs to persons and impact on local employment to the city of Beaumont and Jefferson County.

Response: HHSC assumes that the analyses to which the commenter refers are the Government Growth Impact Statement described by Government Code §2001.0221, the Local Employment Impact Statement described by Government Code §2001.022, and the requirement of Government Code §2001.024(a)(5) that the notice include information regarding the costs to persons required to comply with the rule. These statements must be included in the notice of a proposed rule or rule amendment per Government Code §2001.024(a)(4), (a)(5), and (a)(6). The statements were included in the notice of the proposed rule amendment.

With regard to Government Code §2001.024(a)(4), HHSC believes that the commenter could be referring to the general requirement for fiscal notes described in that section or the Government Growth Impact Statement required by Government Code §2001.0221. The general requirement for fiscal notes was fulfilled, as nothing in Government Code §2001.024(a)(4) requires a state agency to calculate the fiscal effect of a change in policy to governmental entities solely because a provider within those governmental jurisdictions may lose funds.

As to the Government Growth Impact Statement, HHSC restates from the preamble of the proposal that it 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 employee positions;

(3) implementation of the proposed rule will not require an increase or decrease in future legislative appropriations;

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

(5) the proposed rule will create new rules;

(6) the proposed rule will not expand existing rules;

(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 rules' effect on the state's economy.

HHSC also notes that Government Code §2001.0221(c) expressly provides that failure to comply with the section does not impair the legal effect of a rule adopted under Chapter 2001.

With regard to the requirement of Government Code §2001.024(a)(5) that the analysis describe the economic costs to persons regulated by the rule, HHSC restates from the preamble of the proposal that 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 receive a source of federal funds or comply with federal law.

With regard to the Local Employment Impact Statement required by Government Code §2001.022 and §2001.024(a)(6), HHSC restates from the preamble of the proposal that there is a possibility of a negative impact on local employment in some communities and a positive impact in others. The change in methodology from reimbursing uncompensated cost of care for Medicaid and uninsured patients to reimbursing uncompensated cost of care for charity patients for hospital and non-hospital providers will affect the reimbursement to healthcare providers in communities around the state. Certain providers will receive greater reimbursement while others will receive less, depending on the shift in their cost of uncompensated care when calculated using patients who qualify for the providers' charity care policy instead of Medicaid and uninsured patients.

The change in payment amounts will affect revenue received by the healthcare provider, as well as the amount of local and state dollars needed as the non-federal share of the payments. HHSC lacks sufficient data at this time both to predict those communities in which there may be an employment impact and to determine the potential impacts on local employment in those communities. HHSC also notes that Government Code §2001.022(c) provides that failure to comply with this section does not impair the legal effect of a rule adopted under Chapter 2001.

No changes were made in response to this comment.

Comment: One commenter claims that HHSC violated Government Code §2007.043 by failing to provide an assessment of the takings impact of the proposed changes.

Response: HHSC restates from the preamble of the proposal that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code §2007.043. A hospital's not-yet-calculated or received payment under the UC program is not "property" for purposes of the taking clauses of either the federal or state constitutions. Nor does an "expectancy" based upon anticipated continuance of present laws create a vested right for purposes of either the federal or state constitutions. No changes were made in response to this comment.

Uniform Hospital Rate Increase Program (UHRIP) Payments in the UC Calculation

Comment: One commenter proposed that when allocating a portion of DSH payments to offset charity cost, HHSC should modify the calculation to include UHRIP payments as an offset to the Medicaid shortfall.

Response: UHRIP payments are already accounted for in the calculation of the hospital-specific limit and the Medicaid shortfall that occurs in the individual application. For this reason, the UHRIP adjustments do not need to be addressed in the UC payment calculation. The rule was not changed in response to this comment.

Corrections and Clarifications

Comment: One commenter requested clarification on whether there is a requirement to reconcile patients included for UC (S-10 definition) to what was included for the DSH Cap (Uninsured definition) and whether the common patients are removed from the UC calculation.

Response: The common patients are not removed from the UC calculation. The hospital retains the credit for all of the costs of providing services to those charity-care patients in the UC payment calculation. However, as described in §355.8212(g)(2)(A)(i), if there are any DSH payments remaining after offsetting all Medicaid costs and DSH-only costs, those DSH payments in the aggregate will offset UC costs in the calculation. The rule was not changed in response to this comment.

Comment: One commenter wrote that "the DSH Cap uninsured patients are captured for the survey based on discharge date for the fiscal period but S-10 patients are captured using write-off dates. The periods will not perfectly match but we assume you are trying to identify common patient data for the same service date."

Response: HHSC disagrees that the intent is to identify common patients for the same service date; rather, the intent is to identify costs that the hospital may claim in both DSH and UC for the same data period. As described in §355.8212(g)(2), hospitals will self-report those costs on the DSH/UC application. If there are claims on the S-10 that are not eligible to also be claimed for DSH for the same program year because the write-offs fall outside of the data year, then the hospital would not enter those costs on the application. The rule was not changed in response to this comment.

Comment: One commenter wrote that "beginning in 2020 the reconciliation we assume would be for multiple years; for example in 2021 the UC patients would need to be reconciled for common patients in 2021 DSH and to see if any were included in 2020 DSH. If there are common patients in either year we assume they would be identified for 2021 UC."

Response: HHSC disagrees that the reconciliation would be for multiple years. As explained above, it is not necessary to identify common patients between the two programs, so HHSC does not need to perform multi-year reconciliations to capture costs associated with those common patients. The reconciliation is only for one year. As described in §355.8212(i) and §355.8214(i), HHSC will reconcile actual costs incurred by the provider for the demonstration year with UC payments made to the provider for the same period. The rules were not changed in response to this comment.

Comment: One commenter asked HHSC to confirm under 355.8212(g)(4)(A)(i) that a hospital may include physician direct patient care costs of a Texas non-profit health organization that

are reported in the general ledger of a legal entity that meets the CMS definition of "related organization" under 42 CFR 413.17.

Response: The language in the DY 9 UC protocol allows providers to claim all physician costs for direct patient care as long as they are removed as an A-8 or A-8-2 adjustment in their Medicare cost report and can be supported by time studies, contracts, or invoices. Costs that cannot be supported in this way are not allowable. The rule was not changed in response to this comment.

Stability Across Reimbursement Programs

Comment: Several commenters urged HHSC to define stability across reimbursement programs and to use that definition to mitigate losses in UC funding to some provider classes that are caused by the transition to charity-only costs. Commenters provided examples of ways that other programs could be revised, including adjusting rate increases in the UHRIP program and prioritizing resolution of as-yet-unpaid DSH and UC funds from 2014/DY 3 through 2017/DY6.

Response: While these are not direct comments on the methodologies and policies in the proposed UC rule, HHSC agrees that it is appropriate to look at reimbursement across multiple programs to address shifts that may occur among provider classes in UC. HHSC will continue to work with stakeholders to identify potential adjustments to other supplemental payment programs in order to promote equitable and sustainable funding of uncompensated care to all provider types and classes.

Other Changes from the Proposed Version

HHSC made the following changes, not in response to public comments, from the proposed versions of the rules for clarity and completeness:

HHSC amended §355.8208(e), §355.8210(e), and §355.8214(e), concerning payment frequency, to clarify that HHSC will distribute uncompensated-care payments on a schedule to be determined by HHSC and posted on HHSC's website.

HHSC deleted the extra "(2)" in §355.8208(g)(2) that was added inadvertently.

HHSC amended §355.8212(c)(1)(B)(iii)(I)(-b-) to clarify that documentation must be submitted by the "new affiliation cut-off date posted on HHSC Rate Analysis Departments' website."

HHSC amended §355.8212(d) to clarify that HHSC will survey governmental entities to determine the amount of available funding only for the final payment (not for each payment, as originally proposed).

HHSC added §355.8212(f)(4) to clarify that unused funds will be redistributed among provider pools based on each pool's pro-rata share of remaining UC costs for the same demonstration year and that the redistribution will occur when the reconciliation is performed.

HHSC amended §355.8212(g)(3) to clarify the methodology for identifying eligible hospital charity-care costs and the applicable cost-reporting period.

HHSC amended §355.8212(g)(9)(B)(i) to more specifically describe the information that will be used to calculate advance payments in DY 9. Advance payments to hospitals will be based on charity-care costs reported by the hospitals on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with their cost report.

HHSC amended §355.8214(g)(5)(B)(i) to more specifically describe the information that will be used to calculate advance payments in DY 9. Advance payments to physician group practices will be based on documentation submitted by the physician group practice on a form designated by HHSC for that purpose.

ADDITIONAL INFORMATION

For further information, please call: (512) 424-6558.

DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §§355.8202, 355.8208, 355.8210, 355.8212, 355.8214

STATUTORY AUTHORITY

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

§355.8208. Waiver Payments to Publicly-Owned Dental Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible publicly-owned dental providers to help defray the uncompensated cost of charity care. Waiver payments to publicly-owned dental providers for uncompensated care provided before October 1, 2019, are described in §355.8441 of this subchapter (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services).

(b) Definitions.

(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, or its successor.

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

(3) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

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

(8) Publicly-owned dental provider--A dental provider that uses paid government employees to provide dental services directly funded by a governmental entity.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (2) of this subsection.

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

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

(c) Eligibility. To be eligible for payments under this section, a publicly-owned dental provider must submit to HHSC an acceptable uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities.

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

(f) Funding limitations.

(1) Payments made under this section are limited by the amount of funds allocated to the provider's uncompensated-care pool for the demonstration year as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the publicly-owned dental provider pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(3) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all publicly-owned dental providers are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care application. Payments to eligible publicly-owned dental providers are based on cost and payment data reported by the provider on an application form prescribed by HHSC and on supporting documentation. Providers must certify that uncompensated-care costs reported on the application have not been claimed on any other application or cost report.

(2) Calculation. A dental provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, the provider must report their charges associated with charity-care services to uninsured patients and any payments attributable to those services.

(B) A cost-to-billed-charges ratio will be used to calculate total allowable cost.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the publicly-owned dental provider uncompensated-care pool allocation amount. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the publicly-owned dental provider pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool allocation amount.

(h) Payment methodology.

(1) Notice. Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the payment amount for each publicly-owned dental provider in the pool;

(B) the maximum IGT amount necessary for providers in the pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to providers in the pool will be determined based on the amount of funds transferred by the governmental entities as follows:

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the providers will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each provider in the pool will receive a portion of its payment amount for that period, based on the provider's percentage of the total payment amounts for all providers in the pool.

(i) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the provider will be returned to the entity that owns or is affiliated with the provider.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjust-

ments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows:

(A) HHSC will recoup from the provider against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the provider's receipt of HHSC's written notice of recoupment, the provider has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the provider until HHSC has recovered an amount equal to the amount overpaid or disallowed.

§355.8210. Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, Texas Healthcare Transformation and Quality Improvement 1115 Waiver payments are available under this section for eligible governmental ambulance providers to help defray the uncompensated cost of charity care. Waiver payments to governmental ambulance providers for uncompensated care provided before October 1, 2019, are described in §355.8600 of this subchapter (relating to Reimbursement Methodology for Ambulance Services).

(b) Definitions.

(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, or its successor.

(2) Certified public expenditure (CPE)--An expenditure certified by a governmental entity to represent its contribution of public funds in providing services that are eligible for federal matching Medicaid funds.

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

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

(8) Governmental ambulance provider--An ambulance provider that uses paid government employees to provide ambulance services. The ambulance services must be directly funded by a governmental entity. A private ambulance provider under contract with a governmental entity to provide ambulance services is not considered a governmental ambulance provider for the purposes of this section.

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

(10) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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

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

(c) Eligibility.

(1) A governmental ambulance provider must submit a written request for eligibility for supplemental payment in a form prescribed by HHSC to the HHSC Rate Analysis Department by a date specified each year by HHSC. An acceptable request must include:

(A) an overview of the governmental agency;

(B) a complete organizational chart of the governmental agency;

(C) a complete organizational chart of the ambulance department within the governmental agency providing ambulance services;

(D) an identification of the specific geographic service area covered by the ambulance department, by ZIP code;

(E) copies of all job descriptions for staff types or job categories of staff who work for the ambulance department and an estimated percentage of time spent working for the ambulance department and for other departments of the governmental agency;

(F) a primary contact person for the governmental agency who can respond to questions about the ambulance department; and

(G) a signed letter documenting the governmental ambulance provider's voluntary contribution of non-federal funds.

(2) If eligible, a governmental ambulance provider may begin to claim uncompensated-care costs related to services provided on or after the first day of the month after the request for eligibility is approved.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that provide public funds for the governmental ambulance providers in the pool to determine the amount of funding available to support payments from that pool.

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

(f) Funding limitations.

(1) Payments made under this section are limited by the amount of funds allocated to the provider's uncompensated-care pool for the demonstration year as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care). If payments for uncompensated care for the governmental ambulance provider pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(3) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all governmental ambulance providers are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Cost reports. Governmental ambulance providers that are eligible for supplemental payments must submit an annual cost report for ground, water, and air ambulance services delivered to individuals who meet the provider's charity-care policy.

(A) The cost report form will be specified by HHSC. Providers certify through the cost report process their total actual federal and non-federal costs and expenditures for the cost reporting period.

(B) Cost reports must be completed for the full demonstration year for which payments are being calculated. HHSC may require a newly eligible provider to submit a partial-year cost report for their first year of eligibility. The beginning date for the partial-year cost report is the provider's first day of eligibility for supplemental payments as determined by HHSC. The ending date of the partial-year cost report is the last day of the demonstration year that encompasses the cost report beginning date.

(C) The cost report is due on or before March 31 of the year following the cost reporting period ending date and must be certified in a manner specified by HHSC.

(i) If March 31 falls on a federal or state holiday or weekend, the due date is the first working day after March 31.

(ii) A provider may request in writing an extension of up to 30 days after the due date to submit a cost report. HHSC will respond to all written requests for extensions, indicating whether the extension is granted. HHSC must receive a request for extension before the cost report due date. A request for extension received after the due date is considered denied.

(iii) A provider whose cost report is not received by the due date or the HHSC-approved extended due date is ineligible for supplemental payments for the federal fiscal year.

(iv) The individual who completes the cost report on behalf of the provider ("the preparer") must complete the state-sponsored cost report training every other year for the odd-year cost report in order to receive credit to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive training credit to complete the even-year cost report, the preparer must complete an even-year cost report training. No exemptions from the cost report training requirements will be granted.

(D) A cost report documents the provider's actual allowable charity-care costs for delivering ambulance services in accordance with the applicable state and federal regulations. Because the cost report is used to determine supplemental payments, a provider must submit a complete and acceptable cost report to be eligible for a supplemental payment.

(E) The uncompensated-care payment is contingent upon the governmental ambulance provider's CPEs related to charity-care services. There are two CPE forms that must be submitted with each cost report:

(i) The cost report certification form formally acknowledges that the cost report is true, correct, and complete, and was prepared in accordance to all applicable rules and regulations.

(ii) The certification of funds form acknowledges that the claimed expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act, and in accordance with all procedures, instructions, and guidance issued by the single state agency and in effect during the cost report federal fiscal year.

(2) Calculation. An ambulance provider's annual maximum uncompensated-care payment amount is calculated as follows:

(A) As detailed in the cost report instructions, a provider must report their charges associated with charity-care services provided to uninsured patients and any payments attributable to those services.

(B) A provider's total allowable reported costs for ambulance services are allocated to uninsured charity-care patients based on the ratio of charges for uninsured charity-care patients to the charges for all patients. Only allocable expenditures related to uninsured charity care as defined in subsection (b)(3) of this section will be included in calculating the uncompensated-care payment.

(C) The result of subparagraph (B) of this paragraph will be reduced by any related payments reported on the cost report to determine the provider's annual maximum uncompensated-care payment amount.

(3) Reduction to stay within the governmental ambulance provider uncompensated-care pool allocation amount. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the governmental ambulance provider pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts for each provider in the pool by the same percentage as required to remain within the pool allocation amount.

(h) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a provider's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the federal share of the overpayment or disallowance.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows:

(A) HHSC will recoup from the provider against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the provider's receipt of HHSC's written notice of recoupment, the provider has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the provider until HHSC has recovered an amount equal to the amount overpaid or disallowed.

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

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

(b) Definitions.

(1) Affiliation agreement--An agreement, entered into between one or more privately-operated hospitals and a governmental entity that does not conflict with federal or state law. HHSC does not prescribe the form of the agreement.

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

(3) Anchor--The governmental entity identified by HHSC as having primary administrative responsibilities on behalf of a Regional Healthcare Partnership (RHP).

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

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

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

(7) Delivery System Reform Incentive Payments (DSRIP)--Payments related to the development or implementation of a program of activity that supports a hospital's efforts to enhance access to health care, the quality of care, and the health of patients and families it serves. These payments are not considered patient-care revenue and are not offset against the hospital's costs when calculating the hospital-specific limit as described in §355.8066 of this subchapter.

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

(9) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program that serves a disproportionate share of low-income patients and is eligible for additional reimbursement from the DSH fund.

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

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

(12) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

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

(14) Large public hospital--An urban public hospital - Class one as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

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

(A) Certified Registered Nurse Anesthetists;

(B) Nurse Practitioners;

(C) Physician Assistants;

(D) Dentists;

(E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) Optometrists.

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

(17) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(18) RHP plan--A multi-year plan within which participants propose their portion of waiver funding and DSRIP projects.

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

(A) located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or

(B) designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH); or

(C) designated by Medicare as a Rural Referral Center (RRC); and

(i) is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or

(ii) is located in an MSA but has 100 or fewer licensed beds.

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

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

(22) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (5) of this subsection.

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

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

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

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

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

(B) if it is a hospital not operated by a governmental entity, it must have filed with HHSC an affiliation agreement and the documents described in clauses (i) and (ii) of this subparagraph.

(i) The hospital must certify on a form prescribed by HHSC:

(I) that it is a privately-operated hospital;

(II) that no part of any payment to the hospital under this section will be returned or reimbursed to a governmental entity with which the hospital affiliates; and

(III) that no part of any payment to the hospital under this section will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds.

(ii) The governmental entity that is party to the affiliation agreement must certify on a form prescribed by HHSC:

(I) that the governmental entity has not received and has no agreement to receive any portion of the payments made to any hospital that is party to the agreement;

(II) that the governmental entity has not entered into a contingent fee arrangement related to the governmental entity's participation in the waiver program;

(III) that the governmental entity adopted the conditions described in the certification form prescribed by or otherwise approved by HHSC pursuant to a vote of the governmental entity's governing body in a public meeting preceded by public notice published in accordance with the governmental entity's usual and customary practices or the Texas Open Meetings Act, as applicable; and

(IV) that all affiliation agreements, consulting agreements, or legal services agreements executed by the governmental entity related to its participation in this waiver payment program are available for public inspection upon request.

(iii) Submission requirements.

(I) Initial submissions. The parties must initially submit the affiliation agreements and certifications described in this subsection to the HHSC Rate Analysis Department on the earlier of the following occurrences after the documents are executed:

(-a-) the date the hospital submits the uncompensated-care application that is further described in paragraph (2) of this subsection; or

(-b-) the new affiliation cut-off date posted on HHSC Rate Analysis Departments' website for each payment under this section.

(II) Subsequent submissions. The parties must submit revised documentation to HHSC as follows:

(-a-) When the nature of the affiliation changes or parties to the agreement are added or removed, the parties must submit the revised affiliation agreement and related hospital and governmental entity certifications.

(-b-) When there are changes in ownership, operation, or provider identifiers, the hospital must submit a revised hospital certification.

(-c-) The parties must submit the revised documentation thirty days before the projected deadline for completing the IGT for the first payment under the revised affiliation agreement. The projected deadline for completing the IGT is posted on HHSC Rate Analysis Department's website for each payment under this section.

(III) A hospital that submits new or revised documentation under subclause (I) or (II) of this clause must notify the Anchor of the RHP in which the hospital participates.

(IV) The certification forms must not be modified except for those changes approved by HHSC prior to submission.

(-a-) Within 10 business days of HHSC Rate Analysis Department receiving a request for approval of proposed modifications, HHSC will approve, reject, or suggest changes to the proposed certification forms.

(-b-) A request for HHSC approval of proposed modifications to the certification forms will not delay the submission deadlines established in this clause.

(V) A hospital that fails to submit the required documentation in compliance with this subparagraph is not eligible to receive a payment under this section.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must:

(A) submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC; and

(B) submit to HHSC documentation of:

(i) its participation in an RHP; or

(ii) approval from CMS of its eligibility for uncompensated-care payments without participation in an RHP.

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

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

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

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Prior to processing uncompensated-care payments for the final payment period within a waiver demonstration year for any uncompensated-care pool or sub-pool described in subsection (f)(2) of this section, HHSC will survey the governmental entities that provide public funds for the hospitals in that pool or sub-pool to determine the amount of funding available to support payments from that pool or sub-pool.

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

(f) Funding limitations.

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

(2) HHSC will establish the following uncompensated-care pools: a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool.

(A) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned teaching hospitals, state-owned IMDs, and the Texas Center for Infectious Disease.

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

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

(i) For the physician group practice pool, the governmental ambulance provider pool, and the publicly owned dental provider pool:

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

(II) for demonstration years ten and after, an amount to equal a percentage determined by HHSC annually based on factors including the amount of reported charity-care costs for the previous demonstration year and the ratio of reported charity-care costs to hospitals' charity-care costs.

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

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

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

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

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

(g) Uncompensated-care payment amount.

(1) Application.

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

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

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

(ii) For a new hospital, the cost and payment data period may differ from the data year, resulting in the eligible uncompensated costs based only on services provided after the hospital's Med-

icaid enrollment date. HHSC will determine the data period in such situations.

(2) Calculation.

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

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

(I) Use self-reported information on the application to identify charges that can be claimed by the hospital in both DSH and UC and convert the charges to cost;

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

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

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

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

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

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

(iv) For each large public hospital, the amount transferred to HHSC by that hospital's affiliated governmental entity to support DSH payments to that hospital and private hospitals for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (related to inpatient and outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's DSH hospital-specific limit (HSL) plus the unreimbursed costs of non-covered inpatient and outpatient services provided to uninsured charity-care patients.

(3) Hospital charity-care costs.

(A) For each hospital required by Medicare to submit schedule S-10 of the CMS 2552-10 cost report, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with the uninsured charity-care charges reported by the hospital on schedule S-10 for the hospital's cost reporting period ending in the calendar year two years before the demonstration year. For example, for demonstration year 9, which coincides with federal fiscal year 2020, HHSC will use data from the hospital's cost reporting period ending in calendar year 2018.

(B) For each hospital not required by Medicare to submit schedule S-10 of the CMS 2552-10 cost report, the hospital must report its hospital charity-care charges for services provided to uninsured patients for the hospital's cost reporting period ending in the calendar year two years before the demonstration year on the uncompensated-care application described in paragraph (1) of this subsection.

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

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

(4) Other eligible costs.

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

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

(ii) certain pharmacy services.

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

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

(A) A hospital:

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

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

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

(i) Such supporting documentation must include:

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

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

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

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

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

(6) Reduction to stay within uncompensated-care pool allocation amounts. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for any un-

compensated-care pool described in subsection (f)(2) of this section, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible to receive for that period as required to remain within the pool allocation amount.

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

(B) HHSC will calculate the following data points:

(i) For each provider, prior period payments to equal prior period uncompensated-care payments for the demonstration year.

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

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

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

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

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

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

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

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

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

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

(I) For rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all rural hospitals in the pool;

(-b-) in demonstration year:

(-1-) nine, set aside for rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) ten and after, set aside for rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount set aside for rural hospitals in demonstration year nine;

(-c-) calculate a ratio to equal the rural hospital set-aside amount from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(II) For non-rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all non-rural hospitals in the pool;

(-b-) calculate an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the set-aside amount from subclause (I)(-b-) of this clause;

(-c-) calculate a ratio to equal the result from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for non-rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each non-rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(III) The revised maximum uncompensated-care payment for the payment period equals the lesser of:

(-a-) the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph; or

(-b-) the difference between the capped payment amount from subclause (I) or (II) of this clause and the prior period payments from subparagraph (B)(i) of this paragraph.

(IV) HHSC will allocate to each non-state-owned hospital the revised maximum uncompensated-care payment amount from subclause (III) of this clause.

(7) Non-state-owned hospital SDA sub-pools. After HHSC completes the calculations described in paragraph (6) of this subsection, HHSC will place each non-state-owned hospital into a sub-pool based on the hospital's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(8) Prohibition on duplication of costs. Eligible uncompensated-care costs cannot be reported on multiple uncompensated-care applications, including uncompensated-care applications for other programs. Reporting on multiple uncompensated-care applications is duplication of costs.

(9) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be delayed pending data submission or for other

reasons, HHSC may make advance payments to hospitals that meet the eligibility requirements described in subsection (c)(2) of this section and submitted an acceptable uncompensated-care application for the preceding demonstration year from which HHSC calculated an annual maximum uncompensated-care payment amount for that year.

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on uninsured charity-care costs reported by the hospital on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with their cost report; and

(ii) in demonstration years ten and after, be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (6)(B)(i) of this subsection.

(D) A hospital that did not submit an acceptable uncompensated-care application for the preceding demonstration year is not eligible for an advance payment.

(E) If a partial year uncompensated-care application was used to determine the preceding demonstration year's payments, data from that application may be annualized for use in computation of an advance payment amount.

(h) Payment methodology.

(1) Notice. Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the payment amount for each hospital in a pool or sub-pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for hospitals in a pool or sub-pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool or sub-pool will be determined based on the amount of funds transferred by the affiliated governmental entities as follows:

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the hospitals in the pool or sub-pool will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each hospital in the pool or sub-pool will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all hospitals in the pool or sub-pool.

(3) Final payment opportunity. Within payments described in this section, governmental entities that do not transfer the maximum IGT amount described in paragraph (1) of this subsection during a demonstration year will be allowed to fund the remaining payments to hospitals in the pool or sub-pool at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) to the final payments up to the maximum amount; and

(B) to remaining balances for prior payment periods in the demonstration year.

(i) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period:

(1) If a hospital received payments in excess of its actual costs, the overpaid amount will be recouped from the hospital, as described in subsection (j) of this section.

(2) If a hospital received payments less than its actual costs, and if HHSC has available waiver funding for the demonstration year in which the costs were accrued, the hospital may receive reimbursement for some or all of those actual documented unreimbursed costs.

(3) Each hospital that received an uncompensated-care payment during a demonstration year must cooperate in the reconciliation process by reporting its actual costs and payments for that period on the form provided by HHSC for that purpose, even if the hospital closed or withdrew from participation in the uncompensated-care program. If a hospital fails to cooperate in the reconciliation process, HHSC may recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the entity that owns or is affiliated with the hospital.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows:

(A) HHSC will recoup from the hospital against which any overpayment was made or disallowance was directed.

(B) If, within 30 days of the hospital's receipt of HHSC's written notice of recoupment, the hospital has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the hospital until HHSC has recovered an amount equal to the amount overpaid or disallowed.

§355.8214. Waiver Payments to Physician Group Practices for Uncompensated Charity Care.

(a) Introduction. Beginning October 1, 2019, payments are available under this section to help defray the uncompensated charity-care costs incurred by eligible physician group practices described in subsection (c) of this section. Waiver payments to physician group practices for uncompensated care provided before October 1, 2019, are described in §355.8202 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Care). Waiver payments to an eligible physician group practice must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) Definitions.

(1) Allocation amount--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to the physician group practice uncompensated-care pool, as described in §355.8212 of this division (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

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

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

(4) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. Demonstration year one was October 1, 2011, through September 30, 2012.

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

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

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

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

(A) Certified Registered Nurse Anesthetists;

(B) Nurse Practitioners;

(C) Physician Assistants;

(D) Dentists;

(E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) Optometrists.

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

(10) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform. Regional Healthcare Partnerships will support coordinated, efficient delivery of quality care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.

(11) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in paragraph (3) of this subsection.

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

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

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

(c) Eligibility.

(1) A physician group practice is eligible to receive payments under this section if:

(A) it is enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year;

(B) for a private physician group practice only, it has met the submission requirements set forth in §355.8212(c)(1)(B)(iii) of this division, only insofar as that clause relates to certifications, and it files documents with HHSC by the date specified by HHSC, certifying that:

(i) all funds transferred to HHSC as the non-federal share of the waiver payments are public funds; and

(ii) no part of any payment received by the physician group practice under this section will be returned to the governmental entity that transferred to HHSC the non-federal share of the waiver payments;

(C) it has submitted to HHSC an acceptable uncompensated-care physician application for the demonstration year by the deadline specified by HHSC; and

(D) it either:

(i) received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011; or

(ii) is the successor in a contract to a physician group practice that received a supplemental payment under the Texas Medicaid State Plan for claims adjudicated in one or more months between October 1, 2010, and September 30, 2011.

(2) A physician group practice that fails to submit the required documentation in compliance with this subsection will not receive a payment under this section.

(d) Source of funding.

(1) The non-federal share of funding for payments under this section is limited to and obtained through IGTs from the governmental entities that own or are affiliated with the providers in the physician group practice uncompensated-care pool. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year, HHSC will survey the governmental entities that provide public funds for the physician group practices pool to deter-

mine the amount of funding available to support payments from that pool.

(2) An IGT that is not received by the date specified by HHSC may not be accepted.

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

(f) Funding limitations.

(1) Payments made under this section are limited by the maximum amount of funds allocated to the physician group practice uncompensated-care pool for the demonstration year as described in §355.8212 of this division. If payments for uncompensated care for the physician group practice uncompensated-care pool attributable to a demonstration year are expected to exceed the amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(4) of this section.

(2) Payments made under this section are limited by the availability of funds identified in subsection (d) of this section. If sufficient funds are not available for all payments for which all physician group practices are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(g) Uncompensated-care payment amount.

(1) Uncompensated-care physician application. Payments to eligible physician group practices are based on cost and payment data reported by the physician group practice on an application form prescribed by HHSC.

(A) Cost and payment data reported by the physician group practice in the uncompensated-care physician application is used to:

(i) calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection; and

(ii) reconcile the actual uncompensated-care costs reported by the physician group practice for a prior period with uncompensated-care waiver payments, if any, made to the practice for the same period. The reconciliation process is more fully described in subsection (j) of this section.

(B) Unless otherwise instructed in the uncompensated-care physician application:

(i) the cost and payment data reported in the uncompensated-care physician application must be consistent with Medicare cost-reporting principles and must comply with the application instructions or other guidance issued by HHSC, and the physician group practice must maintain sufficient documentation to support the reported data or information; and

(ii) the costs associated with an episode of care where a physician group practice is paid under contract must be reduced by any revenues associated with that episode of care prior to inclusion in the uncompensated-care physician application.

(C) If a physician group practice withdraws from participation in the waiver, the practice must submit an uncompensated-care application reporting its actual costs and payments for any period during which the practice received uncompensated-care payments. The uncompensated-care physician application will be used for the purpose described in subparagraph (A)(ii) of this paragraph. If a practice fails to submit the application reporting its actual costs, HHSC will recoup the full amount of uncompensated-care payments to the practice for the period at issue.

(2) Calculation. A physician group practice's annual maximum uncompensated-care payment amount is the sum of the following components:

(A) its unreimbursed charity-care costs, as reported on the uncompensated-care physician application; and

(B) cost and payment adjustments, if any, as described in paragraph (3) of this subsection.

(3) Adjustments. When submitting the uncompensated-care physician application, physician group practices may request that cost and payment data from the reporting period be adjusted to reflect increases or decreases in costs resulting from changes in operations or circumstances.

(A) A physician group practice may request that:

(i) costs not reflected on the financial documents supporting the application, but which would be incurred for the demonstration year, be included when calculating payment amounts; or

(ii) costs reflected on the financial documents supporting the application, but which would not be incurred for the demonstration year, be excluded when calculating payment amounts.

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

(i) Such supporting documentation must include:

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

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

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

(ii) HHSC will deny a request if it cannot verify that costs not reflected on the financial documents supporting the application will be incurred for the demonstration year.

(4) Reduction to stay within physician group practice uncompensated-care pool allocation amount. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for the physician group practice uncompensated-care pool described in §355.8212 of this division, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible to receive for that period as required to remain within the pool allocation amount.

(A) Calculations in this paragraph are limited to the physician group practice uncompensated-care pool.

(B) HHSC will calculate the following data points:

(i) for each provider, prior period payments to equal prior period uncompensated-care for the demonstration year;

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

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

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

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

(iv) a pool-wide total maximum uncompensated-care payment for the demonstration year to equal the sum of all pool member's annual maximum uncompensated-care payment amounts for the demonstration year from paragraph (2) of this subsection; and

(v) a pool-wide ratio calculated as the pool allocation amount from §355.8212 of this division divided by the pool-wide total maximum uncompensated-care payment amount for the demonstration year from clause (iv) of this subparagraph.

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

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount for the pool, HHSC will calculate a revised maximum uncompensated-care payment for the payment period for each provider in the pool. HHSC will calculate a capped payment amount equal the product of the provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph. The revised maximum uncompensated-care payment for the payment period equals the lesser of:

(i) the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph; or

(ii) the difference between the capped payment amount from this subparagraph and the prior period payments from subparagraph (B)(i) of this paragraph.

(E) Once reductions to ensure that uncompensated-care expenditures do not exceed the allocation amount for the demonstration year for the pool are calculated, HHSC will not re-calculate the resulting payments for any provider for the demonstration year, including if the estimates of available non-federal-share funding upon which the reduction calculations were based are different than actual IGT amounts.

(5) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be delayed pending data submission or for other reasons, HHSC may make advance payments to physician group practices that meet the eligibility requirements described in subsection (c) of this section and submitted an acceptable uncompensated-care physician application for the preceding demonstration year from which HHSC calculated an annual maximum uncompensated-care payment amount for that year.

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on documentation submitted by the physician group practice on a form designated by HHSC for that purpose ; and

(ii) in demonstration years ten and after, be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (4)(B)(i) of this subsection.

(D) A physician group practice that did not submit an acceptable uncompensated-care physician application for the preceding demonstration year is not eligible for an advance payment.

(E) If a partial year uncompensated-care physician application was used to determine the preceding demonstration year's payments, data from that application may be annualized for use in computation of an advance payment amount.

(6) Prohibition on duplication of costs. Eligible uncompensated-care costs cannot be reported on multiple uncompensated-care applications, including uncompensated-care applications for other programs. Reporting on multiple uncompensated-care applications is duplication of costs.

(h) Payment methodology.

(1) Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the payment amount for each physician group practice in the pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for the physician group practices to receive the amount described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) The amount of the payment to the physician group practices under paragraph (1) of this subsection will be determined based on the amount of funds transferred by the affiliated governmental entities as described as follows:

(A) If the governmental entities transfer the maximum amount of funds described in paragraph (1)(B) of this subsection, the physician group practices will receive the maximum allowable payment amounts for that period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1)(B) of this subsection, each physician group practice in the pool will receive a portion of its payment amount for that period, based on the physician group practice's percentage of the total payment amounts for all physician group practices in the pool.

(i) Reconciliation. Data on the uncompensated-care physician application will be used to reconcile actual costs incurred by the physician group practice for a prior period with uncompensated-care payments, if any, made to the physician group practice for the same period.

(1) If a physician group practice received payments in excess of its actual costs, the overpaid amount will be recouped from the physician group practice, as described in subsection (j) of this section.

(2) If a physician group practice received payments less than its actual costs, and if HHSC has available waiver funding for the period in which the costs were accrued, the physician group practice may receive reimbursement for some or all of those actual documented unreimbursed costs.

(j) Recoupment.

(1) In the event of a disallowance by CMS of federal financial participation related to a physician group practice's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the physician group practice will be returned to the entity that owns or is affiliated with the physician group practice.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows:

(A) HHSC will recoup from the physician group practice against which any disallowance was directed or to which an overpayment was made.

(B) If, within 30 days of the physician group practice's receipt of HHSC's written notice of recoupment, the physician group practice has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so, HHSC may withhold any or all future Medicaid payments from the physician group practice until HHSC has recovered an amount equal to the amount overpaid or disallowed.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805552
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: July 27, 2018
For further information, please call: (512) 424-6558

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DIVISION 23. EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

1 TAC §355.8441

STATUTORY AUTHORITY

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

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805553
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: July 27, 2018
For further information, please call: (512) 424-6558

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DIVISION 31. AMBULANCE SERVICES

1 TAC §355.8600

STATUTORY AUTHORITY

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

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805554
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: July 27, 2018
For further information, please call: (512) 424-6558

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 87. OMBUDSMAN SERVICES

The Texas Health and Human Services Commission (HHSC) adopts new §§87.101, 87.103, 87.105, 87.107, 87.111, 87.113, 87.115, 87.117, 87.119, 87.205, 87.209, 87.211, 87.213, 87.215, 87.217, 87.219, 87.315, 87.319, 87.401, 87.403, 87.405, 87.407, 87.409, 87.411, 87.413, 87.415, 87.417, and 87.419 in Title 26, Part 1, Chapter 87, concerning Ombudsman Services, with changes to the proposed text as published in the June 22, 2018, issue of the *Texas Register* (43 TexReg 4053). Sections 87.109, 87.201, 87.203, 87.207, 87.301, 87.303, 87.305, 87.307, 87.309, 87.311, 87.313, 87.317, and 87.321, also in Chapter 87, are adopted without changes to the proposed text as published in the June 22, 2018, issue of the *Texas Register* (43 TexReg 4053), and therefore will not be republished.

BACKGROUND AND JUSTIFICATION

The new chapter clarifies and details how the Office of the Ombudsman (OO), reauthorized by Senate Bill 200, 84th Legislature, Regular Session, 2015, assists the public and Health and Human Services (HHS) consumers with inquiries and complaints. Chapter 87 also serves the purpose of including various Ombudsman responsibilities and services for different programs and administrative areas in one chapter.

OO is established by Texas Government Code, §531.0171, Office of Ombudsman, and has authority and responsibility over the HHS system in providing dispute resolution services, performing consumer protection and advocacy functions, and collecting consumer contact data.

The Ombudsman Managed Care Assistance Team (OMCAT) provides support and information services to persons enrolled in or applying for Medicaid who experience barriers to receiving health care services, in accordance with Texas Government Code, §531.0213, Support Services for Medicaid Recipients.

The Ombudsman for Children and Youth in Foster Care (FCO), established by Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830, 84th Legislature, Regular Session, 2015, serves as a neutral party in assisting children and youth in the conservatorship of the Department of Family and Protective Services (DFPS) with complaints regarding issues within the authority of DFPS or HHS.

The Ombudsman for Behavioral Health Access to Care (OBH) established by Texas Government Code, §531.02251, Ombudsman for Behavioral Health Access to Care, serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

COMMENTS

The 30-day comment period ended on July 22, 2018.

During this period, HHSC received comments regarding the proposed rules from eight commenters, including the Texas Medical Association, the Private Providers Association of Texas, the Texas Council of Community Centers, the Coalition for Nurses in Advanced Practice, Disability Rights Texas, the Texas Hospital Association, the Texas Coalition of Healthy Minds, and the National Alliance on Mental Illness - Texas. A summary of comments relating to the rules and HHSC's responses follows.

Comment: Regarding proposed §87.101 (Definitions), multiple commenters suggested adding a definition for "health care provider" and/or "behavioral health care provider."

Response: HHSC agrees and has added a definition of "health care provider." This term is used throughout the Chapter and includes any licensed provider who is authorized under state law to provide health care services, or a credentialed professional who provides behavioral health, mental health, or substance use disorder services. Conforming edits were made to §87.105(c) to reflect calls from providers. An edit was made to §87.215(b) to remove example provider types no longer necessary with the definition of "health care provider."

Comment: One commenter suggested including a definition for "local behavioral health authority" (LBHA) where local mental health authorities were referenced.

Response: HHSC agrees and has included a definition of "local behavioral health authority" in §87.101(11). References to LMHAs throughout the Chapter have been updated to include LBHAs.

Comment: One commenter recommended clarifying the definition of "Substantiated complaint."

Response: HHSC declines to revise the rule in response to this comment, but notes §87.115(b) which outlines the types of policy OO staff review when determining whether a complaint is substantiated.

Comment: Regarding the proposed §87.103 (Creation of the Office and Populations Served), one commenter suggested language indicating OO was responsible for identifying trends and patterns in complaints and disputes and advocating for systemic remedies.

Response: HHSC declines to revise the rule in response to this comment. The language in §87.103(a)(1) is taken from Texas Government Code, §531.0171. However, OO agrees complaint data should be tracked, analyzed, and reported with a systemic approach in mind and notes related language in §87.109(d).

Comment: Multiple commenters asked for clarification of the "HHS program" a consumer should first contact with their inquiry or complaint, per §87.103(b).

Response: This depends on the HHS benefit or service the consumer is seeking. For example, a consumer seeking eligibility for Supplemental Nutrition Assistance Program food benefits should first contact HHSC Access & Eligibility staff, while a consumer seeking a Medicaid managed care service should first contact their Medicaid health plan. OO will consider including additional examples on its web site and in consumer materials. No change was made to the rule in response to this comment.

Comment: One commenter asked for clarification of how directing a consumer to first contact the HHS program for which they have an inquiry or complaint complies with federal guidance to hospitals that requires patients to be advised they may lodge a grievance with the state.

Response: In the specific context of hospitals, OBH works with patients at state hospitals administered by the state, so the HHS program is itself part of the state. HHSC's Regulatory Division responds to complaints about facilities they regulate; these rules do not govern their process. No change was made to the rules in response to this comment.

Comment: One commenter recommended §87.103(d)(2) be revised to clarify OO remains impartial by receiving and reviewing each contact in an objective and fair manner, free from bias "and prejudice," and treating all parties without favor or prejudice.

Response: HHSC disagrees and declines to revise the rule in response to this comment. The language in this section comes from the United States Ombudsman Association's government ombudsman standards, and the recommendation appears to be redundant.

Comment: Regarding §87.105 (Contact Information), one commenter recommended adding "HHS directories" to the list of documents OO produces with its contact information, and multiple commenters asked that material distribution by OO be required in this section as well as in §87.205 (Contact Information) and §87.405 (Contact Information).

Response: HHSC disagrees and declines to revise the rule in response to these comments. These rules outline OO's responsibilities but existing HHS policy requires each HHS program to provide its consumers with OO's contact information. For example, some programs include OO's contact information on consumer handbooks, on consumer websites, or notices of case actions sent to consumers. While OO does produce rights handbooks for some consumers, other handbooks are produced by program staff and OO does not wish to duplicate those efforts. For example, OBH produces rights handbooks for consumers receiving behavioral health services, but Medicaid managed care organizations produce member handbooks that are required to include OO's contact information.

Comment: Multiple commenters asked if it was possible for one toll-free number to be available for all OO programs.

Response: Consolidating all OO calls intake to one toll-free line would either require staff dedicated just to sorting calls or a voice prompt system that would be burdensome to consumers. OO staff answering each toll-free number transfer consumers to other OO programs as needed.

Comment: Multiple commenters suggested clarification of the availability of OO outreach materials for providers in §87.105, §87.205 (Contact Information), and §87.405. Additionally, they suggested clarification that health care providers can contact OO.

Response: HHSC agrees and revised text in §87.105(a), §87.105(c), §87.205(a), §87.205(c), §87.405(a), and §87.405(c).

Comment: Regarding proposed §87.107 (Confidentiality), multiple commenters suggested clarification of what OO does when a health care provider contacts OO. They also asked for clarification of whether OO could follow-up with providers.

Response: HHSC legal staff have determined OO is not a "health oversight agency" and does not conduct "program evaluations" per HIPAA. They have also determined OO does not perform "health care operations" per the Texas Medical Records Privacy Act. OO must have permission from either a consumer or the consumer's legally authorized representative, which may include a consumer's health care provider, before OO staff can share information about their HHSC case, including following-up when OO's case is closed. However, OO is not prevented from taking information from a health care provider and working with the consumer or their legally authorized representative. The text of §87.107(b), §87.117(a), §87.119(c), §87.217(b), §87.417(b), and §87.419(d) have been revised accordingly.

Comment: One commenter suggested clarification that OO can transmit a consumer's confidential information or protected health information through a non-secure format, if the consumer or the consumer's legally authorized representative consents.

Response: HHSC agrees and revised text in §87.107(d) to reflect this change.

Comment: Regarding §87.109 (Data and Reports), one commenter suggested text to require the monthly report of consumer contacts be available on the HHS website.

Response: HHSC disagrees and declines to revise the rule in response to this comment. Texas Government Code §531.0171(d) does not direct this report to be on the HHS website. The report is subject to disclosure in response to an Open Records request.

Comment: One commenter requested clarification as to whether monthly trend analysis is limited to the top five contact reasons.

Response: The text of §87.109(d)(2) lists items that must be included, but does not prohibit additional analysis. No change was made to the rule in response to this comment.

Comment: Regarding proposed §87.111 (Referrals to Other HHS Offices or Other Entities) and §87.411 (Referrals to Other HHS Offices or Entities), multiple commenters suggested clarification that OO can inform a health care provider of a referral.

Response: HHSC agrees and has revised the rule accordingly.

Comment: Multiple commenters suggested clarification of how OO handles cases involving individuals receiving IDD services in the community.

Response: Individuals receiving IDD services in the community through Home and Community-based Services or the Texas Home Living Program, or an individual receiving services from a local IDD authority are referred to the Consumer Rights Intellectual Disability team. This team is currently part of HHSC's Regulatory Division and is scheduled to transfer to OO in January 2019. Following this transition, OO will propose an update to Chapter 87 to outline procedures for this population.

Comment: One commenter suggested OO should not refer consumers threatening violence to themselves or others to an LMHA.

Response: HHSC disagrees and declines to revise the rule in response to this comment. Assisting consumers in crisis is a responsibility of LBHAs and LMHAs, who maintain crisis hotlines available 24 hours a day, seven days a week.

Comment: Regarding proposed rule §87.113 (Intake of Contacts), §87.213 (Intake of Contacts), and §87.413 (Intake of Contacts), multiple commenters asked that HHSC clarify OO staff notifies a health care provider of OO's roles and responsibilities when they begin to review a contact.

Response: HHSC agrees and has revised the rules accordingly.

Comment: Regarding proposed §87.115 (Research and Communication with HHS Programs), §87.215 (Research and Communication with HHS Programs, Health Care Providers, and Medicaid Managed Care Organizations), §87.315 (Research Using DFPS and HHS Systems and Policies), and §87.415 (Research and Communication with HHS Programs and Agencies that Regulate Health Plans), multiple commenters suggested adding "internal procedures and policies" to the list OO staff review to determine if HHS policy was followed.

Response: HHSC agrees with these comments and has revised the rules accordingly. This clarifies that OO also reviews internal program policies and procedures in its investigations to determine if HHS policy was followed by HHS staff and contracted vendors.

Comment: Multiple commenters suggested clarification that OO requests a response from HHS staff when research through available systems is not sufficient to address a provider's complaint.

Response: HHSC agrees and has revised §87.115(d) and §87.215(d) accordingly.

Comment: One commenter suggested clarification of what OO staff do if no response is received after a second request, and who determines whether that response is adequate.

Response: HHSC agrees and has revised §87.115(e), §87.115(f), §87.215(e), §87.215(f), and §87.415(a)(5) to indicate that if still no response is received, the request is escalated to leadership within the program. OO staff determine whether a complaint can be substantiated. If OO staff find a program response inadequate, OO staff refer the contact back to the program for additional review.

Comment: Regarding proposed §87.119 (Substantiating and Closing Complaints) and §87.319 (Substantiating and Closing Complaints), one commenter suggested written summaries of OO findings should always be provided to consumers in order to maintain a record.

Response: HHSC disagrees and declines to revise the rule in response to this comment. A written summary is provided, if requested, and documentation of OO's finding is maintained in OO's tracking system.

Comment: Regarding proposed Subchapter B (Ombudsman Managed Care Assistance), one commenter expressed confusion about the role of OMCAT in relation to Medicaid's Research & Resolution team.

Response: HHSC agrees there has been confusion on this point, and is currently working to clarify Medicaid consumer materials. Per federal regulations, Medicaid health plans are required to provide their members a grievance and appeals process. While HHSC operates under a "no wrong door" approach to receipt of complaints by agency staff, Medicaid consumer complaints are handled by OMCAT and Medicaid provider complaints are handled by Medicaid's Research & Resolution team. No change was made to the rules in response to this comment.

Comment: Regarding proposed §87.203 (Creation of the Program and Populations Served), one commenter suggested adding a specific reference to consumers seeking long term services and supports.

Response: HHSC disagrees and declines to revise the rule in response to this comment. The language in §87.203(c) is from Texas Government Code §531.0213.

Comment: Regarding proposed §87.209 (Reports), multiple commenters suggested OMCAT reports be posted on the HHS website.

Response: HHSC agrees and has revised the rule as suggested, which is authorized by Texas Government Code §531.0213(d)(5).

Comment: Regarding proposed §87.211 (Referrals to Other HHS Offices or Other Entities), one commenter asked for clarification of the language on referral of fair hearings and appeals requests.

Response: When a consumer or their legally authorized representative contacts OMCAT with a request for a fair hearing, OMCAT staff send that request to the HHSC Appeals Division staff responsible for the fair hearings process. Similarly, if a consumer contacts OMCAT indicating they wish to appeal a decision of their Medicaid health plan, OMCAT staff send that request to the appropriate health plan. In these situations, OMCAT staff also consider if there is any other way they can assist the consumer. No change was made to the rule in response to this comment.

Comment: Regarding proposed §87.215 (Research and Communication with HHS Programs, Health Care Providers, and Medicaid Managed Care Organizations), one commenter asked what responsibility an LMHA providing services to a Medicaid health plan has for responding to OMCAT.

Response: OMCAT requests information directly from Medicaid health plans, and seeks assistance from OBH on behavioral health cases. OBH may seek information from an LMHA per §87.415(a). No change was made to the rule in response to this comment.

Comment: Regarding proposed Subchapter C (Ombudsman for Children and Youth in Foster Care), one commenter expressed concern about the ability of young children to access services via the toll-free line.

Response: HHSC shares this concern and notes the in-person option for the FCO program in §87.305(c)(5). As part of a recent effort to document the relationship between HHSC and DFPS after implementation of House Bill 5, 85th Legislature, Regular Session, 2017, the agencies agreed to collaborate on procedures for getting FCO staff access to youth in residential treatment centers, hospitals, and placements under the new Community Based Care model. No change was made to the rule in response to this comment.

Comment: Regarding proposed §87.309 (Data and Reports), one commenter suggested adding a requirement that the FCO annual report include a listing of policy issues which require resolution.

Response: HHSC disagrees and declines to revise the rule in response to this comment. The text in §87.309(c) comes from Texas Government Code 531.998, as enacted by Senate Bill 830, 84th Legislature, Regular Session, 2015. However, HHSC notes the annual report includes a listing of the most frequent contact reasons for substantiated complaints, including reference to the related DFPS or HHS policy.

Comment: Regarding proposed §87.319 (Substantiating and Closing Complaints), one commenter suggested a program corrective action should only be required for substantiated complaints.

Response: HHSC agrees and has revised the rule as suggested.

Comment: One commenter recommended against use of "BHO" as an acronym for the Ombudsman for Behavioral Health, as it is commonly used to refer to behavioral health organizations.

Response: HHSC agrees and revised the reference to the Ombudsman for Behavioral Health throughout the Chapter to "OBH" and changed the name to Subchapter D from "Behavioral Health Ombudsman" to "Ombudsman for Behavioral Health." In §87.401, the definition for "Ombudsman for Behavioral Health" was moved below "IDD-Intellectual and developmental disabilities" to account for updating the abbreviation.

Comment: Regarding proposed §87.405 (Contact Information), one commenter suggested additional requirements for distribution of OBH's contact information.

Response: HHSC disagrees and declines to revise the rule in response to this comment. The list included in §87.405(b) is based on 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services).

Comment: Regarding proposed §87.409 (Data and Reports), multiple commenters requested a requirement that OBH summaries to the Mental Health Condition and Substance Use Disorder Parity Work Group be posted to the HHS web site.

Response: HHSC disagrees and declines to revise the rule in response to this comment. Video recordings of Work Group meetings, which include OBH's reports, are available in archive on the HHS web site.

Comment: Regarding proposed §87.415 (Research and Communication with HHS Programs and Agencies that Regulate Health Plans), one commenter suggested allowing LMHAs additional time to respond to OBH requests.

Response: In response to a comment about §87.115, HHSC removed reference to this response timeframe.

Comment: Multiple commenters suggested clarification that OBH provides a health care provider information about filing an appeal or complaint with a consumer's health plan.

Response: HHSC agrees and has revised §87.415(b)(4) as suggested.

In addition to revisions made in response to public comments, HHSC made some revisions on its own motion. In §87.101(12), a grammatical change was made. In §87.101(13) a conforming change was made to the LMHA definition. In §87.103(c), a statutory reference was corrected. A minor editorial change was made to §87.103(e)(1) to correct a grammatical error. In §87.115, §87.215, and §87.415, references to specific response timeframes were removed and the subsections or paragraphs were relabeled accordingly due to the edits. In §87.119, §87.219, §87.319, and §87.419, references to specific resolution timeframes were removed and the subsections or paragraphs were relabeled accordingly due to the edits. In §87.407(a) and §87.409(a), a revision was made to reflect the new name of the Health & Specialty Care System.

ADDITIONAL INFORMATION

For further information, please call: (512) 706-7120.

SUBCHAPTER A. OFFICE OF THE OMBUDSMAN

26 TAC §§87.101, 87.103, 87.105, 87.107, 87.109, 87.111, 87.113, 87.115, 87.117, 87.119

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §§531.0171, 531.0213, and 531.02251; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830,84th Legislature, Regular Session, 2015; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHSC Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies.

§87.101. Definitions.

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

(1) Compact with Texans--A document that describes the Texas Health and Human Services Commission's services, principles, and the process for filing complaints and requesting information.

(2) Complaint--Any expression of dissatisfaction by a consumer of a Texas Health and Human Services (HHS) program or service about HHS benefits or services. Complaints do not include the following, which are handled through other processes:

(A) allegations of abuse, neglect, or exploitation;

(B) allegations of discrimination or other civil rights violations;

(C) allegations of fraud, waste, or abuse;

(D) requests for Fair Hearings or administrative appeals; or

(E) concerns about regulated individuals and entities.

(3) Consumer--An applicant or a client of HHS programs, as well as a member of the public seeking information about HHS programs.

(4) Contact--A consumer's written or oral inquiry or complaint about HHS programs or services.

(5) Dispute resolution services--An independent and impartial review of a program's actions regarding an HHS consumer complaint that has not been resolved to the consumer's satisfaction.

(6) Health care provider--A physician, pharmacist, or other licensed provider who is authorized under state law to provide health care services, or a credentialed professional who provides behavioral health, mental health, or substance use disorder services.

(7) HEART--HHS enterprise administrative report and tracking system. A web-based system that the HHSC Office of the Ombudsman and some HHS programs use to track inquiries and complaints.

(8) HHS--Texas Health and Human Services. The system for providing or otherwise administering health and human services in this state established in Texas Government Code Chapter 531, comprised of HHSC and the Department of State Health Services.

(9) HHSC--Texas Health and Human Services Commission. The agency established by Texas Government Code Chapter 531.

(10) Inquiry--A request by a consumer for information about HHS programs or services.

(11) LBHA--Local behavioral health authority. An entity designated as the local behavioral health authority in accordance with the Texas Health and Safety Code §533.0356(a).

(12) Legally authorized representative--A person legally authorized to act on behalf of an individual with regard to a matter described in this chapter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

(13) LMHA--Local mental health authority. An entity designated as the local mental health authority in accordance with the Texas Health and Safety Code §533.035(a).

(14) OO--Office of the Ombudsman. The HHSC office established by Texas Government Code §531.0171, with oversight of the HHS system.

(15) Substantiated complaint--A complaint for which research clearly indicates HHS policy was violated or HHS expectations were not met.

(16) Unable to substantiate a complaint--A complaint for which research does not clearly indicate if HHS policy was violated or HHS expectations were met.

(17) Unsubstantiated complaint--A complaint for which research clearly indicates HHS policy was not violated or HHS expectations were met.

§87.103. Creation of the Office and Populations Served.

(a) OO is established by Texas Government Code §531.0171.

(1) OO has authority and responsibility over the HHS system in:

(A) providing dispute resolution services;

(B) performing consumer protection and advocacy functions; and

(C) collecting consumer contact data.

(2) OO is responsible for a standard process for tracking and reporting consumer contacts within the HHS system, including centralized tracking of consumer contacts submitted to field, regional, or other local offices.

(b) HHSC's Compact With Texans outlines customer service principles and standards, including a complaint process for consumers. As part of that process, a consumer is directed to first contact the HHS program for which they have an inquiry or a complaint. If the concern is not resolved to the consumer's satisfaction, the consumer is directed to contact OO. In accordance with HHSC's Compact With Texans, OO is committed to providing high quality services in a professional and ethical manner by:

(1) treating consumers with courtesy and respect;

(2) ensuring access to and provision of services is fair and equitable;

(3) implementing new and creative approaches to improve quality of services;

(4) operating based on consumers' overall needs and feedback;

(5) providing understandable information in a variety of formats;

(6) ensuring sound management of programs and funds;

(7) working in cooperation with consumers; and

(8) protecting private information and sharing public information in accordance with applicable laws.

(c) In accordance with Texas Government Code §531.0171(b), OO does not have authority to process case actions or overturn HHS program decisions. OO staff also cannot give legal advice.

(d) OO strives to adhere to the United States Ombudsman Association's government ombudsman standards by:

(1) maintaining independence from HHS programs through an organizational structure that has OO report to the HHSC Executive Commissioner through a separate chain of command than program staff;

(2) remaining impartial by receiving and reviewing each contact in an objective and fair manner, free from bias, and treating all parties without favor or prejudice;

(3) maintaining discretion to keep confidential or release information related to a contact or a complaint investigation, if authorized by a consumer to do so; and

(4) providing a credible review process by performing responsibilities in a manner that engenders respect, confidence, and accessibility to all consumers.

(e) Several ombudsman programs are part of OO.

(1) The Ombudsman Managed Care Assistance Team (OMCAT) provides support and information services to persons enrolled in or applying for Medicaid who experience barriers to receiving health care services, in accordance with Texas Government Code §531.0213. Administrative rules for this program can be found in Subchapter B of this chapter (relating to Ombudsman Managed Care Assistance).

(2) The Ombudsman for Children and Youth in Foster Care (FCO) established by Texas Government Code Chapter 531, Subchapter Y, as enacted by Senate Bill 830 (84th Legislature, Regular Session, 2015). FCO serves as a neutral party in assisting children and youth in the conservatorship of the Department of Family and Protective Services (DFPS) with complaints regarding issues within the authority of DFPS or an HHS agency. Administrative rules for this program can be found in Subchapter C of this chapter (relating to Ombudsman for Children and Youth in Foster Care).

(3) The Ombudsman for Behavioral Health access to care (OBH) established by Texas Government Code §531.02251. OBH serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders. Administrative rules for this program can be found in Subchapter D of this chapter (relating to Behavioral Health Ombudsman).

(4) The State Long-term Care Ombudsman authorized by Texas Human Resources Code Subchapter F of Chapter 101a; 42 USC 3058f and 3058g; and 45 CFR Part 1324. The purpose of the State Long-term Ombudsman program is to protect the health, safety, welfare, and rights of people living in nursing facilities and assisted living facilities. Administrative rules for this program can be found in 26 TAC Chapter 88 (relating to State Long-term Care Ombudsman Program).

§87.105. Contact Information.

(a) OO staff maintain a public website with its contact information and develop brochures and other materials that can be distributed to consumers and health care providers.

(b) Each HHS office that provides direct service delivery of programs or services offers a process to a consumer to submit complaints and advises the consumer how to contact OO staff if that office does not resolve the complaint to the consumer's satisfaction. These HHS programs ensure OO contact information is provided on appropriate web pages, in written materials (such as consumer handbooks and denial notices), and is available upon request in local offices. This includes communications made to a consumer by a vendor contracted to provide services on behalf of an HHS program.

(c) An HHS consumer, the consumer's legally authorized representative, or a health care provider may contact OO staff through the following methods:

(1) Toll-free phone, relating to:

(A) A consumer, call 1-877-787-8999 (8:00 a.m. to 5:00 p.m., Central Standard Time, Monday through Friday).

(B) A consumer needing help with accessing services under a managed care plan, call 1-866-566-8989.

(C) A foster youth, call 1-844-286-0769.

(D) A consumer seeking behavioral health services, call 1-800-252-8154.

(E) A resident of a nursing facility or an assisted living facility, call 1-800-252-2412.

(F) A person who has a hearing or speech disability, call 7-1-1 or 1-800-735-2989.

(2) Toll-free fax: 1-888-780-8099.

(3) Mail: HHS Office of the Ombudsman, P.O. Box 13247, Austin TX 78711-3247.

(4) Online: hhs.texas.gov/ombudsman.

§87.107. Confidentiality.

(a) Before sharing a consumer's information, OO staff confirm the identity of the individual receiving the information by following the requirements outlined in Texas Works Handbook, Part B, Section 1200 (Confidentiality), which can be found on HHSC's web page at hhs.texas.gov/laws-regulations/handbooks.

(b) If a person other than a consumer or the consumer's legally authorized representative contacts OO staff, including a health care provider, the person is told OO staff can take information from them but that OO staff must have permission from either the consumer or the consumer's legally authorized representative before OO staff can share information about their HHSC case.

(c) OO staff obtain a consumer's consent before sharing the consumer's information with anyone other than HHS staff involved in the review of the contact. Consent can be obtained from the consumer's legally authorized representative.

(d) OO staff follow HHSC's policies relating to transmission of consumer data, including use of secure email to encrypt messages that contains a consumer's confidential information or protected health information. OO staff can transmit data in a non-secure format if the consumer or the consumer's legally authorized representative consents in writing.

§87.111. Referrals to Other HHS Offices or Other Entities.

OO staff inform the consumer, the consumer's legally authorized representative, or a health care provider of any referral made to other HHS offices or other entities regarding their contact with OO and document the referral in the HEART system. Referrals include:

(1) Department of Family and Protective Services, for a contact that includes information that makes OO staff suspect abuse, neglect, or exploitation;

(2) HHSC Civil Rights Office, for a contact alleging a violation of civil rights or discrimination regarding the delivery of HHS programs or services, including those concerning lack of access to benefits and services due to language or disability;

(3) Office of Inspector General, for a contact that includes allegations of fraud, waste, or abuse regarding HHS programs or services;

(4) HHSC Appeals Division staff, for a request for a fair hearing;

(5) Medicaid managed care organization, for a request to appeal a decision by a Medicaid managed care organization;

(6) HHSC Regulatory Services Division, for a contact related to an entity regulated by HHSC; and

(7) LBHA or LMHA closest to the consumer or local law enforcement, for a contact that includes threats of violence to a consumer or others.

§87.113. Intake of Contacts.

(a) A contact received through an online submission is automatically loaded in the HEART system and assigned to available OO staff for action.

(b) A contact received by postal mail, fax, or email is uploaded to the HEART system and assigned to available OO staff for action within one business day of receipt.

(c) A call received by OO staff is immediately entered in the HEART system.

(d) When OO staff begin to review a contact, they take the following actions:

(1) notify the consumer, the consumer's legally authorized representative, or a health care provider of OO's roles and responsibilities;

(2) explain any referrals to other HHS staff or external organizations that are recommended;

(3) explain the OO complaint resolution process;

(4) clarify the preferred method and timeline of follow-up communications; and

(5) provide an estimated timeline in which a response can be expected.

(e) OO staff use HHSC's contracted vendors to provide language interpretation services, when necessary.

§87.115. Research and Communication with HHS Programs.

(a) OO staff review all available information about a consumer through inquiry into HHS program systems before referring a contact to HHS staff for review.

(b) Each complaint is investigated to determine if HHS policy was followed by HHS staff and vendors contracted to provide services on behalf of an HHS program. Applicable policies include federal and state law, administrative rules, program handbooks, contracts, and internal program policies and procedures.

(c) OO staff consider the following when investigating a complaint:

(1) Legal authority. What is the basis of the HHS program's decision, and was the decision made within the scope of that authority?

(2) Procedural fairness and rights. Was the consumer given a full understanding of the situation, offered all applicable opportunities to appeal, and given sufficient time to respond when information was requested?

(3) Agreed expectations. Did the HHS program follow through after agreeing to take particular actions, and did the program provide an adequate explanation of decisions?

(d) When OO staff research through available systems is not sufficient to address a concern or determine whether a complaint can be substantiated, OO staff request a response to the complaint from appropriate HHS staff.

(e) HHS staff are asked to respond to OO requests. If no response is received, a second communication is made, and documented in the HEART system. If still no response is received, the request is escalated to leadership within the HHSC program.

(f) Upon receipt of information from HHS staff, OO staff review to determine if the concern has been addressed and if OO staff can determine whether a complaint can be substantiated. If the response is found to be inadequate by OO staff or if additional information is

required, OO staff refer the contact back to HHS staff for additional review.

§87.117. Follow-up with Consumers.

(a) OO staff follow-up with a consumer or the consumer's legally authorized representative within five business days of the date of receipt of a contact, and then at least every ten business days thereafter, until the contact is closed. If the consumer provides consent, OO staff also follow-up with the consumer's health care provider.

(b) State law and HHS policy require disclosure of an employee's full name, work phone number, and work email address, if requested by a consumer. However, a consumer or the consumer's legally authorized representative is asked to use the OO toll-free line and shared email address when corresponding with OO staff.

(c) A consumer or the consumer's legally authorized representative requesting the direct phone number or individual email address of any HHS staff not already listed on the HHS website, including OO staff, is directed to HHSC's Open Records process.

§87.119. Substantiating and Closing Complaints.

(a) Once OO staff have determined all pertinent information has been gathered and their investigation of a complaint is complete, they determine if it is substantiated, unsubstantiated, or unable to be substantiated.

(b) A consumer or the consumer's legally authorized representative is notified of the outcome of a complaint. A written summary is provided upon request of a consumer or the consumer's legally authorized representative, or if OO staff cannot reach the consumer by telephone to relay the findings. If the consumer provides consent and requests, OO staff also notify the consumer's health care provider of the outcome.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805555
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

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SUBCHAPTER B. OMBUDSMAN MANAGED CARE ASSISTANCE

26 TAC §§87.201, 87.203, 87.205, 87.207, 87.209, 87.211, 87.213, 87.215, 87.217, 87.219

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §§531.0171, 531.0213, and 531.02251; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830,84th Legislature, Regular Session, 2015; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHSC Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies.

§87.205. Contact Information.

(a) OO staff maintain a public website for OMCAT with its contact information and develop brochures and other materials that can be distributed to consumers and Medicaid health care providers.

(b) In accordance with requirements of the Uniform Managed Care Manual maintained by HHSC Medicaid program staff and available on the HHSC web site, each MCO includes OMCAT contact information on its member web sites and in member handbooks.

(c) An HHS consumer, the consumer's legally authorized representative, or a health care provider may contact OMCAT through the following methods:

(1) toll-free phone:

(A) 1-866-566-8989 (8:00 a.m. to 5:00 p.m., Central Standard Time, Monday through Friday); or

(B) 7-1-1 or 1-800-735-2989 for a person who has a hearing or speech disability;

(2) toll-free fax: 1-888-780-8099;

(3) mail to HHS Office of the Ombudsman, Managed Care Assistance Team, P.O. Box 13247, Austin TX 78711-3247; or

(4) online: hhs.texas.gov/ombudsman.

§87.209. Reports.

(a) OMCAT collects and maintains statistical information on contacts relating to each MCO, by region and Medicaid managed care program.

(b) Reports of OMCAT contacts are distributed to HHSC executive staff and Medicaid program staff quarterly and are posted on the HHS website. The reports include the number of contacts by region, trends identified in delivery of services and access to care complaints, identified recurring barriers, and other problems identified with Medicaid managed care.

§87.211. Referrals to Other HHS Offices or Other Entities.

(a) If a consumer or the consumer's legally authorized representative contacts OMCAT seeking information or wishing to complain about an HHS program other than Medicaid, the consumer or the consumer's legally authorized representative is transferred to OO staff that handle complaints regarding those programs. OMCAT staff inform the consumer or the consumer's legally authorized representative of this referral and document it in the HEART system.

(b) A request for a fair hearing is referred to HHSC Appeals Division staff. A request for an appeal of a decision by an MCO is referred to that entity. OMCAT staff inform the consumer or the consumer's legally authorized representative of these referrals and document them in the HEART system.

(c) A request from a Medicaid health care provider that does not relate to a consumer's Medicaid case is referred to the HHSC office designated to receive these complaints, in accordance with the Texas Medicaid Provider Procedures Manual maintained by HHSC Medicaid program staff and available on the HHS web site. OMCAT staff inform the health care provider of this referral and document it in the HEART system.

§87.213. Intake of Contacts.

(a) A contact received through an online submission is automatically loaded in the HEART system and assigned to available OMCAT staff for action.

(b) A contact received by postal mail, fax, or email is uploaded to the HEART system and assigned to available OMCAT staff for action within one business day of receipt.

(c) A call received by OMCAT staff is immediately entered in the HEART system.

(d) When OMCAT staff begin to review a contact, they take the following actions:

(1) notify the consumer, the consumer's legally authorized representative, or a health care provider of OMCAT's roles and responsibilities;

(2) explain any referrals to other HHS staff or external organizations that are recommended;

(3) explain the OMCAT complaint resolution process;

(4) clarify the preferred method and timeline of follow-up communications; and

(5) provide an estimated timeline in which a response can be expected.

§87.215. Research and Communication with HHS Programs, Health Care Providers, and Medicaid Managed Care Organizations.

(a) OMCAT staff review all available information about a consumer through inquiry into HHS program systems before referring a contact to HHS staff or MCO staff for review.

(b) OMCAT staff may contact a consumer's health care provider as part of their work on a contact.

(c) Each complaint is investigated to determine if HHS policy was followed by HHS staff and vendors contracted to provide services, including MCO staff. Applicable policies include federal and state law, administrative rules, the MCO's contract with HHSC, and internal program policies and procedures.

(d) When OMCAT research through available systems is not sufficient to address a concern or determine whether a complaint can be substantiated, OMCAT staff request a response to the complaint from appropriate MCO staff. OMCAT staff may also contact the consumer's health care provider directly in order to resolve a complaint.

(e) MCO staff are asked to respond to an OMCAT request. If no response is received, a second communication is made, and documented in the HEART system. If still no response is received, the request is escalated to leadership within the HHSC Medicaid program.

(f) Upon receipt of information from MCO staff, OMCAT staff review to determine if the concern has been addressed and if OMCAT staff can determine whether the complaint can be substantiated. If the response is found to be inadequate by OMCAT staff or if additional information is required, OMCAT staff refer the contact back to MCO staff for additional review.

(g) OMCAT staff may seek assistance from HHSC Medicaid program staff on some contacts, at the discretion of OMCAT's managing ombudsman.

§87.217. Follow-up with Consumers.

(a) OMCAT staff follow-up with a consumer or the consumer's legally authorized representative within five business days of the date of receipt of the contact, and then at least every ten business days thereafter, until the contact is closed.

(b) If the consumer provides consent, OO staff also follow-up with the consumer's health care provider.

§87.219. Substantiating and Closing Complaints.

Once OMCAT staff have determined all pertinent information has been gathered and their investigation of a complaint is complete, they determine if the complaint is substantiated, unsubstantiated, or unable to be substantiated.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805556
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

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SUBCHAPTER C. OMBUDSMAN FOR CHILDREN AND YOUTH IN FOSTER CARE

26 TAC §§87.301, 87.303, 87.305, 87.307, 87.309, 87.311, 87.313, 87.315, 87.317, 87.319, 87.321

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §§531.0171, 531.0213, and 531.02251; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830,84th Legislature, Regular Session, 2015; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHSC Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies.

§87.315. Research Using DFPS and HHS Systems and Policies.

(a) FCO staff review any available information about a foster care case through inquiry into DFPS and HHS systems, including IMPACT and CLASS, and any system used by vendors contracted to provide services on behalf of DFPS.

(b) Each complaint is investigated to determine if DFPS or HHS policy was followed by agency staff and vendors contracted to provide services on behalf of DFPS or an HHS program. Applicable policies include federal and state law, administrative rules, program handbooks, contracts, and internal program policies and procedures.

(c) If FCO staff discover a violation of DFPS or HHS policy during the course of their research that was not outlined in the original submission from the youth, an additional complaint is entered in the existing HEART record.

(d) If FCO staff determine a youth is adjudicated, they note this in the contact record and outreach to the Independent Ombudsman for the Texas Juvenile Justice System to determine if coordination would be helpful.

(e) FCO staff request a response to the complaint from appropriate DFPS or HHS staff, or vendors contracted to provide services on behalf of DFPS or HHS, if the youth has authorized sharing of the youth's information.

§87.319. Substantiating and Closing Complaints.

(a) Once FCO staff have determined all pertinent information has been gathered and their investigation of a complaint is complete, they enter a resolution in the contact record, choosing substantiate, unable to substantiate, or unsubstantiated.

(b) For substantiated complaints, FCO staff also enter a program corrective action based on the response provided by program staff.

(c) An FCO complaint cannot be closed without a resolution and, for substantiated complaints, a program corrective action.

(d) The complaint record documents informing program staff and the youth of the resolution.

(e) A written response to program staff includes additional recommended corrective actions, when applicable. Regardless of whether DFPS, a vendor contracted to provide services on behalf of DFPS, or an HHS agency was the subject of the youth's complaint, DFPS is provided a copy of the written response to program staff.

(f) A written response may be provided to the youth, if requested, and includes:

(1) a description of the steps taken to investigate the complaint;

(2) a general description of what FCO found as a result of the investigation; and

(3) if a complaint is:

(A) substantiated, a description of the actions taken by DFPS, a vendor contracted to provide services on behalf of DFPS, or the HHS agency in response to that finding; or

(B) unsubstantiated, a description of additional steps the youth can take to have someone review the youth's concern (e.g., speak to a court-appointed advocate or to the judge assigned to the youth's case).

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805557
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

SUBCHAPTER D. OMBUDSMAN FOR BEHAVIORAL HEALTH

26 TAC §§87.401, 87.403, 87.405, 87.407, 87.409, 87.411, 87.413, 87.415, 87.417, 87.419

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §§531.0171, 531.0213, and 531.02251; Texas Government Code, Chapter 531, Subchapter Y, as enacted by Senate Bill 830,84th Legislature, Regular Session, 2015; and Texas Government Code §531.0055, General Responsibility for Health and Human Services System, which provides that the HHSC Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies.

§87.401. Definitions.

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

(1) IDD--Intellectual and developmental disabilities.

(2) OBH--Ombudsman for Behavioral Health. The ombudsman for behavioral health access to care established by the Texas Government Code §531.02251.

(3) Parity--The requirement outlined in Texas Insurance Code Subchapter F of Chapter 1355 that a health benefit plan provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

(4) State hospital--A state mental health facility operated by HHSC.

§87.403. Creation of the Program and Populations Served.

(a) OBH is established by Texas Government Code §531.02251, and is administratively attached to OO.

(b) OBH serves as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders. OBH identifies, tracks, and helps report potential violations of Texas Insurance Code Subchapter F of Chapter 1355.

(c) OBH advocates for the rights and service needs of consumers who have questions, concerns, or complaints regarding services provided by a state hospital or an LBHA or LMHA. Specific rights of these consumers are outlined in 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services).

§87.405. Contact Information.

(a) OO staff maintain a public website with OBH contact information and develop brochures and other materials that can be distributed to consumers seeking behavioral health services and health care providers.

(b) In accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services), OBH's toll-free number is published in consumer rights handbooks made available at all service locations at state hospitals or LBHAs or LMHAs. Consumers at these facilities also have a right to be verbally explained all of their rights -- including the right to complain to OBH -- within 24 hours of admission. Additional situations that require a state hospital or an LBHA or LMHA to notify a consumer of OBH's contact information include:

(1) any time an LBHA or LMHA determines a consumer is not in their priority population during the admission screening process, as outlined in 25 TAC 412.161 (Screening and Assessment);

(2) any time an LBHA or LMHA determines a consumer requesting interstate transfer is not eligible for admission to a state hospital; and

(3) in each state hospital and LBHA or LMHA's "Notice of Privacy Practice."

(c) A consumer, the consumer's legally authorized representative, or a health care provider may contact OBH through the following methods:

(1) toll-free phone:

(A) 1-800-252-8154 (8:00 a.m. to 5:00 p.m., Central Standard Time, Monday through Friday); or

(B) 7-1-1 or 1-800-735-2989 for a person who has a hearing or speech disability;

(2) toll-free fax: 1-888-780-8099;

(3) mail to HHS Office of the Ombudsman, Ombudsman for Behavioral Health, P.O. Box 13247, Austin TX 78711-3247; or

(4) online at hhs.texas.gov/ombudsman.

§87.407. Confidentiality.

(a) OBH staff adhere to statutory requirements and policy of the HHSC Health & Specialty Care System when protecting records of consumers receiving services at state hospitals.

(b) OBH staff adhere to statutory requirements and policy of the HHSC IDD-Behavioral Health Services Department when protecting records of consumers receiving services at LBHAs or LMHAs.

(c) OBH staff obtain a consumer's consent before sharing the consumer's information with anyone other than HHS staff or LBHA or LMHA staff required to receive and respond to OBH complaints. This includes sharing information with a federal or state agency that regulates a consumer's health plan. Consent can be obtained from the consumer's legally authorized representative.

§87.409. Data and Reports.

(a) OBH staff have access to data and systems maintained by the HHSC Health & Specialty Care System and the HHSC IDD-Behavioral Health Services Department necessary to complete their investigation of a contact. Specifically, OBH staff have access to the Client Assignment and Registration (CARE) system.

(b) In accordance with Texas Government Code §531.02251(g), OBH is part of the Mental Health Condition and Substance Use Disorder Parity Work Group and provides summary reports of concerns, complaints, and potential parity violations.

§87.411. Referrals to Other HHS Offices or Other Entities.

(a) If a consumer, the consumer's legally authorized representative, or a health care provider contacts OBH seeking information or wishing to complain about an HHS program other than behavioral health, the consumer, the consumer's legally authorized representative, or the health care provider is transferred to OO staff that handle complaints regarding those programs. OBH staff inform the consumer, the consumer's legally authorized representative, or the health care provider of this referral and document it in the HEART system.

(b) A resident of a state supported living center (SSLC), the consumer's legally authorized representative, or a health care provider is referred to the Office of the Independent Ombudsman for SSLCs established by Texas Health and Safety Code Subchapter C of Chapter 555. OBH staff inform the consumer, the consumer's legally authorized representative, or the health care provider of this referral and document it in the HEART system.

(c) A consumer, the consumer's legally authorized representative, or a health care provider seeking to complain about treatment of a substance use disorder at a facility regulated by the HHSC Regulatory Services Division or seeking to complain about inappropriate commitment at a facility regulated by the HHSC Regulatory Services Division is transferred to staff in that division. OBH staff inform the consumer, the consumer's legally authorized representative, or the health care provider of this referral and document it in the HEART system.

(d) A referral is made to the HHSC Regulatory Services Division for a consumer receiving IDD services in the community through Home and Community-based Services or the Texas Home Living Program, a consumer receiving services from a local IDD authority, or the legally authorized representative or health care provider of one of these consumers. OBH staff inform the consumer, the consumer's legally authorized representative, or the health care provider of this referral and document it in the HEART system.

(e) A consumer presenting with concerns of imminent threat to the health or safety of the consumer or others is conferenced with LBHA or LMHA crisis services or local law enforcement. OBH staff stay connected with the consumer until crisis services are obtained. OBH staff document the referral in the HEART system.

(f) A contact that relates to interstate transfer of a consumer in need of behavioral health services is referred to the HHSC Emergency Services Program's Repatriation Program. OBH staff inform the consumer, the consumer's legally authorized representative, or a health care provider of this referral and document it in the HEART system.

(g) A contact where a consumer, the consumer's legally authorized representative, or a health care provider alleges a HIPAA violation by state hospital staff is referred to the HHSC Privacy Office. A contact where a consumer, the consumer's legally authorized representative, or the health care provider alleges a HIPAA violation by an LBHA or LMHA staff is referred to the LBHA's or LMHA's contract manager within HHSC's IDD-Behavioral Health Services Department. OBH staff inform the consumer, the consumer's legally authorized representative, or the health care provider of the referral and document it in the HEART system.

§87.413. Intake of Contacts.

(a) A contact received by postal mail, fax, or online submission is uploaded to the HEART system and assigned to available OBH staff for action within 24 hours of receipt.

(b) A call received by OBH staff is immediately entered in the HEART system.

(c) When OBH staff begin to review a contact, they take the following actions:

(1) notify the consumer, the consumer's legally authorized representative, or a health care provider of OBH's roles and responsibilities;

(2) explain any referrals to other HHS staff or external organizations that are recommended;

(3) explain the OBH complaint resolution process;

(4) clarify the preferred method and timeline of follow-up communications; and

(5) provide an estimated timeline in which a response can be expected.

§87.415. Research and Communication with HHS Programs and Agencies that Regulate Health Plans.

(a) For a contact involving a consumer receiving services at a state hospital or an LBHA or LMHA:

(1) OBH staff review all available information about a consumer through inquiry into HHS program systems before referring a

contact to the rights protection officer at the relevant state hospital or LBHA or LMHA, who are responsible for receiving complaints from OBH, per 25 TAC 404.164 (Rights Protection Officer at Department Facilities and Community Centers).

(2) Each complaint is investigated to determine if HHS policy was followed by HHS staff and vendors contracted to provide services, including LBHA or LMHA staff. Applicable policies include federal and state law, administrative rules, HHSC contracts, and internal program policies and procedures.

(3) When OBH research through available systems is not sufficient to address the concern or determine whether a complaint can be substantiated, OBH staff request a response from the rights protection officer at the relevant state hospital or LBHA or LMHA, if the consumer has consented to discussion of the contact.

(4) Upon receipt of a response from a rights protection officer, OBH staff review to determine if the concerns have been addressed and if OBH staff can determine whether a complaint can be substantiated. If the response is found to be inadequate by OBH staff or if additional information is required, OBH staff refer the contact back to the rights protection officer for additional review.

(b) For a contact involving a consumer seeking behavioral health services through the consumer's health plan:

(1) OBH staff refer a potential violation of Texas Insurance Code Subchapter F of Chapter 1355, to the appropriate regulatory or oversight agency.

(A) A referral for a consumer with private insurance, the child health plan established under Chapter 62 of the Texas Health and Safety Code or insurance bought through the federal Healthcare.gov Marketplace is made to the Texas Department of Insurance.

(B) A referral for a consumer whose employer offers a self-funded plan is made to the U.S. Department of Labor or, if applicable, the public agency that administers the plan.

(C) A referral for a consumer with Medicaid is made to the HHSC Medicaid & CHIP Services Department.

(D) A referral for a consumer with Medicare is made to the U.S. Department of Health and Human Services' Medicare Ombudsman program.

(E) A referral for a consumer with Tricare is made to the U. S. Department of Defense's Defense Health Agency, Hearing and Claim's Collection Division.

(2) OBH staff attempt to get a consumer to provide a copy of the explanation of benefits or denial letter from the consumer's health plan, which is submitted to the appropriate regulatory or oversight agency.

(3) A contact relating to a potential parity violation is left open until a response is received from the appropriate regulatory or oversight agency.

(4) OBH staff also provide a consumer, the consumer's legally authorized representative, or a health care provider information about how to file an appeal or a complaint with the consumer's health plan.

§87.417. Follow-up with Consumers.

(a) OBH staff follow-up with a consumer or the consumer's legally authorized representative within five business days of the date of receipt of a contact, and then at least every ten business days thereafter, until the contact is closed.

(b) If the consumer provides consent, OBH staff also follow-up with the consumer's health care provider.

§87.419. Substantiating and Closing Complaints.

(a) Once OBH staff have determined all pertinent information has been gathered and their investigation of a complaint is complete, they determine if the complaint is substantiated, unsubstantiated, or unable to be substantiated.

(b) A written response requested by a consumer or the consumer's legally authorized representative includes:

(1) a description of the steps taken to investigate the complaint;

(2) a description of what OBH found as a result of their investigation; and

(3) if a complaint is:

(A) substantiated, a description of the actions taken in response; or

(B) unsubstantiated, a description of additional steps the consumer can take to have someone review the consumer's concerns (e.g., a referral to Disability Rights Texas).

(c) If the consumer provides consent, OBH staff also notify the consumer's health care provider of the outcome of a complaint.

(d) OBH staff notify the rights protection officer that reviewed a case of the OBH finding. On a substantiated complaint, the superintendent of the relevant state hospital or the HHSC staff responsible for enforcement of the LBHA or LMHA contract is also asked to respond with a summary of actions taken. If a response is received, OBH staff upload the response into the HEART system.

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

Filed with the Office of the Secretary of State on December 21, 2018.

TRD-201805558
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: January 10, 2019
Proposal publication date: June 22, 2018
For further information, please call: (512) 706-7120

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TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 148. HEARINGS CONDUCTED BY THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

28 TAC §148.17

The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts with changes amendments to §148.17,

relating to Administrative Penalties, now retitled Special Provisions for Sanctions. The proposed amendments were published in the *Texas Register* on November 9, 2018 (43 TexReg 7445). DWC received two comments on the proposed amendments. No public hearing was requested.

These amendments will align the rule with changes made to Texas Labor Code §415.035, *Judicial Review,* by House Bill (HB) 1456, 85th Legislature, Regular Session (2017). HB 1456 deleted the requirement that, when an administrative penalty is assessed, a person must pay the penalty or post a bond while seeking judicial review of the administrative decision.

Adopted amendments to §148.17 delete much of the existing text and replace it with language requiring, unless otherwise stated in a final and unappealable order from the commissioner of workers' compensation or a court, that a charged party must comply with a sanction within 30 days of the order becoming final and unappealable. The adopted amendments also allow for other forms of monetary payments of penalties approved by DWC. The adopted amendments also retitle the section, and otherwise make editorial changes to reformat and renumber the rule.

SUMMARY OF COMMENTS AND AGENCY RESPONSE

COMMENT: One commenter supported the amendments as proposed.

RESPONSE: DWC appreciates the supportive comment. No change was made in response to the comment.

COMMENT: One commenter suggested that §148.17(a) be revised to clarify that neither the commissioner nor a court may require compliance with a sanction before an order is final and unappealable.

RESPONSE: DWC appreciates the comment. This clarification is consistent with DWC's intent for the proposed rule. Subsection (a) has been revised so that it provides that "unless otherwise stated in a final, unappealable order from the commissioner or a court, a charged party must comply with the sanctions no later than 30 days after the order becomes final and unappealable."

COMMENT: One commenter proposed that §148.17(b) be revised to clarify that penalties must be paid according to the schedule provided for in subsection (a).

RESPONSE: DWC appreciates the comment but disagrees that any clarification is necessary. The Code Construction Act provides a presumption that an entire statute or rule is intended to be effective, that a just and reasonable result is intended, and that a result feasible of execution is intended. Texas Government Code §311.021. This requires that the rule be read as whole, that subsections (a) and (b) be read together. Subsection (a) addresses when parties must comply with ordered sanctions. Subsection (b) sets forth how any penalties resulting from a sanction are to be paid and does not address, nor is it intended to address, the timing of those payments. No change was made in response to this comment.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: Office of Injured Employee Counsel

For, with changes: Texas Medical Association

The amendments are adopted under Labor Code §§402.00111, 402.00128. 402.061, and 415.035. The adopted amendments support the implementation of the Workers' Compensation Act, Texas Labor Code Title 5, Subtitle A.

Section 402.00111, provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Section 402.00128, authorizes the commissioner to conduct the daily operations of DWC and otherwise implement division policy.

Section 402.061, provides that the commissioner of workers' compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Section 415.035, provides for judicial review of decisions under §415.034, relating to hearing procedures.

§148.17. Special Provisions for Sanctions.

(a) Unless otherwise stated in a final, unappealable order from the commissioner or a court, a charged party must comply with a sanction no later than 30 days after the order becomes final and unappealable.

(b) If an order imposing a sanction assesses a penalty against the charged party, the charged party must file the amount of the penalty with the Chief Clerk of Proceedings in the form of a cashier's check, a certified check, a certified draft, or other form of payment authorized by the division.

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

Filed with the Office of the Secretary of State on December 20, 2018.

TRD-201805549
Nicholas Canaday III
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: January 9, 2019
Proposal publication date: November 9, 2018
For further information, please call: (512) 804-4703

CHAPTER 180. MONITORING AND ENFORCEMENT

The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts with changes the amendment of 28 Texas Administrative Code (TAC) §180.8, *Notices of Violation; Notices of Hearing; Default Judgments* and adopts with changes the amendment of §180.26, *Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies.* DWC first published proposed amendments to §180.8 and §180.26 as published in the May 18, 2018, issue of the *Texas Register* (43 TexReg 3226). A public hearing was held on August 2, 2018. In response to written comments received and comments during the August 2, 2018, public hearing, DWC withdrew its first proposal.

On November 2, 2018, DWC proposed new amendments as published in the *Texas Register* (43 TexReg 7328). A public hearing was held on November 16, 2018. In response to comments, no changes have been made to the amendment of §180.8, as proposed. The only changes were to make grammar and citation corrections as they related to the Texas Administrative Code. Changes have been made to the amendment of

§180.26. Proposed §180.26(i)(2)(C) was deleted, removing the requirement that system participants must acknowledge in all consent orders that the ordered sanction is appropriate. While this deletion does not preclude DWC and a system participant from agreeing to include such an acknowledgement in a consent order, DWC, based on public comments, determined that requiring such an acknowledgement in all consent orders could unnecessarily restrict parties seeking informal disposition of an enforcement matter in some cases. For the same reason, DWC also deleted the word "appropriately" from §180.26(i)(2)(B). Additional non-substantive amendments were made to §180.26 in response to the public comments submitted.

Section 180.8 and §180.26 relate to DWC's enforcement process. The adopted amendments are necessary to implement Senate Bill (SB) 1895, 85th Legislature, Regular Session. SB 1895 amended Labor Code §415.021(c), *Assessment of Administrative Penalties,* to require that the commissioner consider additional factors when assessing an administrative penalty and added subsection (c-1), which directs the commissioner to adopt rules requiring DWC to communicate certain information when assessing administrative penalties, including the relevant statute or rule violated, the conduct that gave rise to the violation, and the factors considered in the determination of a penalty.

Amended §180.8(b)(4) requires that a Notice of Violation (NOV) include a statement of the basis for the proposed sanction. This statement will include a description of the underlying facts considered by DWC for each of the factors considered in DWC's determination of the proposed sanction, the description of which factors under Labor Code §415.021(c) or Rule §180.26 had a mitigating or aggravating effect on the proposed sanctions, and a description of the proposed sanction for each violation or violation type in the case of repeated administrative violations. Rule §180.8 currently requires that the NOV include the statute or rule violated, the conduct that gave rise to the violation, and a description of a proposed sanction. This additional language will implement SB 1895 and ensure that DWC communicates all necessary information to affected persons when assessing administrative penalties or other sanctions.

Amended §180.8(c) requires that Notices of Hearing include a description of the underlying facts considered, a description of which factors under Labor Code §415.021(c) and §180.26 had a mitigating or aggravating effect, and a description of the proposed sanction DWC intends to impose.

Amended §180.26(h) and (i) implement the provisions in Labor Code §415.021(c-1) which require that DWC "communicate to the person information about the penalty, including: (1) the relevant statute or rule violated; (2) the conduct that gave rise to the violation; and (3) the factors considered in determining the penalty." DWC currently communicates this information to persons subject to an administrative violation, and §180.26(e) already requires DWC to consider the factors listed in Labor Code §415.021(c) when determining which sanction to impose and the severity of such a sanction. The additional language in these amendments will implement SB 1895 by memorializing DWC's current practices and ensuring that DWC communicates all necessary information when assessing administrative penalties or other sanctions.

The amendment to §180.26(i) requires that consent orders include a statement of the factors DWC considered aggravating or mitigating when determining the proposed sanction. Furthermore, the amendment to §180.26(i) requires that consent orders include a statement acknowledging that DWC and the system participant communicated regarding the information described by amended §180.26(h) and that DWC considered the factors under Labor Code §415.021(c) and §180.26(e). Additional non-substantive editorial changes are made to §180.26 to align its language with DWC's style guide and to correct grammatical errors.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: Two commenters support the amendments as proposed. These commenters agree that the amendments advance the legislative intent underlying SB 1895. Additionally, one commenter noted that the new rule language facilitates due process notice requirements for administrative enforcement actions.

Response: DWC appreciates the supportive comments. No change was made in response to these comments.

Section 180.8

Comment: Commenter recommends deleting the term "appropriateness of" from §180.8(b)(4)(A) because it is ambiguous. Appropriateness, the commenter states, may reflect an individual's opinion or belief at a particular point in time and can change with the times, or as leaders within the agency change. Additionally, the commenter states that Labor Code §415.021(c) does not require the commissioner to consider appropriateness but only certain delineated factors. The commenter states that the words "appropriateness of" may add to disputed issues at a hearing or unnecessarily complicate informal resolution through consent orders.

Response: DWC appreciates the comment. Under the Workers' Compensation Act, DWC determines an appropriate sanction through consideration of underlying facts, the laws at issue, and the relevant factors under Labor Code §415.021(c). This process is commonplace as there are many provisions within the Act that require DWC to determine appropriateness, including, but not limited to, §§414.003(b) ("commissioner shall use the information compiled under this section to impose appropriate penalties and other sanctions under Chapters 415 and 416"), 402.00128(b)(7) (DWC may "enter appropriate orders"), 413.0512(c)(1) ("the medical quality review panel shall recommend to medical advisor appropriate action regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organizations"), and 408.023(c) ("The commissioner may also consider the practice restrictions of an applicant when determining appropriate sanctions under Section 408.0231"). Moreover, the NOV is a statement of the facts that DWC must prove and a description of why DWC believes a proposed sanction is appropriate. If the case is heard at the State Office of Administrative Hearings, DWC must establish the appropriateness of any sanction sought. No change was made in response to this comment.

Comment: Commenter supports the proposed language in §180.8(b)(4)(C) because it will give additional information as to how DWC may have arrived at an aggregate sanction amount and suggests similar language be added to §180.26.

Response: DWC appreciates the supportive comment but declines to add the suggested language to §180.26(h). This communication will occur as part of the negotiation of a consent order, but these elements do not need to be set forth in the consent order itself. Thus, it is important that DWC and system participants continue to have flexibility to negotiate the terms of indi-

vidual consent orders. No change was made in response to this comment.

Section 180.26

Comment: In reference to §180.26(h), a commenter inquired why the required communications for the informal procedure are materially different than the required communications for a formal notice under proposed §180.8(b)(4). Commenter contends that the required communications should be similar, if not identical. Commenter also recommends that §180.26(h)(3) be amended to include communications similar to those proposed in §180.8(b)(4).

Response: DWC appreciates the comment but declines to make the change because an NOV and a consent order serve different purposes and are used at different phases of the enforcement process. The elements of an NOV, which is a formal document and referred to in §180.8, are not the same as a consent order, which is described in §180.26. An NOV is the first step in formal enforcement proceedings whereas negotiation prior to consent order is part of informal disposition. An NOV is prepared and served upon a respondent after attempts to resolve the matter informally have failed. This makes the relevant matters to be communicated by DWC through an NOV and proposed consent order materially different. No change was made in response to this comment.

Comment: Commenter recommends deleting "appropriateness" and "appropriately" from §180.26(h)(3). Commenter states that Labor Code §415.021(c) does not require the use of the term "appropriately considered" or set any type of standard for determination of appropriateness. SB 1895 only requires that the factors enumerated in Labor Code §415.021(c) be considered.

Response: DWC appreciates the comment. The communications between DWC and stakeholders that may produce a consent order logically are structured to produce, for the purpose of compromise, an understanding of the proposed sanctions, including how DWC considered the factors under Labor Code §415.021 and why DWC believes the proposed sanction is appropriate. Therefore, the term "appropriateness" has not been deleted from the first sentence of §180.26(h)(3).

However, DWC has modified the text of §180.26(h)(3) by changing "whether" to "how" and removing "appropriately" in order to align it with §180.8(b)(4)(A). This change corrects a redundancy and adds clarity without substantively changing the rule.

Comment: Commenter disagrees with the proposed language in §180.26(i) that states "Consent Orders must include" and opposes mandatory language in consent orders. Commenter states that nothing in the Labor Code, Tex. Gov. Code Chapter 2001, or SB 1895 authorizes DWC to enact rules regulating the terms or language in a consent order. Commenter states that Tex. Gov. Code §2001.056 does not dictate what terms must be in an informal disposition and further states that the proposed rule could be in conflict with this statute. Commenter recommends replacing the term "must" with the term "may" to remove the mandatory prescription.

Response: DWC appreciates the comment. "Must" aligns the rule, as amended, with the legislature's statement of requirements - an obligatory term - set forth in Labor Code §415.021(c-1). DWC is not seeking to regulate or adopt rules under Government Code §2001.056. DWC is simply prescribing the requirements for commissioner orders under Labor Code §402.061 and §402.00128. No changes were made in response to this comment.

Comment: Commenter recommends deleting §180.26(i)(2)(B) and (C) because these subparagraphs require system participants to acknowledge that DWC "appropriately" considered the factors and that the ordered sanction is "appropriate." Commenter states that system participants should be able to agree to informal disposition without admitting that either a violation or sanction was appropriately considered by DWC. Commenter further states that the deletion would give more flexibility for both DWC and system participants to negotiate an informal disposition.

Response: DWC appreciates the comment. DWC declines to delete subparagraph (B) in its entirety because §415.021(c-1)(3) requires that as part of a consent order DWC communicate the factors it considered in the determination of a proposed penalty. However, DWC has deleted subparagraph (C) and the term "appropriately" from subparagraph (B) to allow for more flexibility between the parties during negotiations.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Concentra and Office of Injured Employee Counsel

For, with changes: Insurance Council of Texas

SUBCHAPTER A. GENERAL RULES FOR ENFORCEMENT

28 TAC §180.8

Amended §180.8 and §180.26 are adopted under the authority of Labor Code §§402.00111, 402.00116, 402.00128, 402.061, 415.021, and 415.032. The adopted amendments support the implementation of the Workers' Compensation Act, Labor Code Title 5, Subtitle A.

Labor Code §402.00111 states that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Texas Workers' Compensation Act.

Labor Code §402.00116 states that the commissioner of workers' compensation is DWC's chief executive and administrative officer and shall administer and enforce the Texas Workers' Compensation Act, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner of workers' compensation.

Labor Code §402.00128 states that the commissioner of workers' compensation shall conduct the daily operations of DWC and otherwise implement policy and, among other functions, may delegate, assess, and enforce penalties; and enter appropriate orders.

Labor Code §402.061 states that the commissioner shall adopt rules, as necessary, for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §415.021 states that the commissioner shall adopt rules that require DWC, in the assessment of an administrative penalty against a person, to communicate to the person information about the penalty, including the relevant statute or rule violated, the conduct that gave rise to the violation, and the factors considered in determining the penalty.

Labor Code §415.032 states that if an investigation by DWC indicates that an administrative violation has occurred, DWC shall

notify the person alleged to have committed the violation in writing of various items including the charge. This statute also states steps the person alleged is required to take before the 20th day the noticed was received.

§180.8. Notices of Violation; Notices of Hearing; Default Judgments.

(a) A notice of violation (NOV) is a notice issued to a system participant when the division finds that the system participant has committed an administrative violation and the division seeks to impose a sanction under the Act or division rules. An NOV is not required to be issued before or after the issuance of an ex parte emergency cease and desist order.

(b) An NOV shall be in writing and include:

(1) the provision(s) of the Act, rule, order, or decision of the commissioner that the system participant violated;

(2) a summary of the facts that establish that the violation(s) occurred;

(3) a description of the proposed sanction that the division intends to impose;

(4) a statement of the basis for the proposed sanction including:

(A) a description of the underlying facts considered by the division for each of the factors listed in Labor Code §415.021(c) (relating to Assessment of Administrative Penalties) and §180.26 of this title (relating to Criteria for Proposing, Recommending and Determining Sanctions; Other Remedies) in determining the appropriateness of the division's proposed sanction;

(B) a description of which factors under Labor Code §415.021(c) and §180.26 of this title had a mitigating or aggravating effect on the division's proposed sanctions; and

(C) a description of the division's proposed sanction for each violation or violation type in the case of repeated administrative violations. This requirement does not prohibit the division from considering the aggregate impact of all administrative violations described in the NOV when proposing a sanction if justice requires such consideration;

(5) the right to consent to the charge and the proposed sanction(s);

(6) the right to request a hearing; and

(7) other information about the rights, obligations, and procedures for requesting a hearing.

(c) The charged party shall file a written answer to the NOV not later than the twentieth day after the day the notice is received. The answer shall either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing by being filed with the division's chief clerk of proceedings. If the charged party fails to respond to the NOV within 20 days of receipt of the notice, the division shall schedule a hearing at the State Office of Administrative Hearings (SOAH) and provide notice of hearing to the charged party that meets the requirements of §148.5 of this title (relating to Notice of Hearing) and must include the information in subsection (b)(3) and (4) of this section.

(d) A charged party that receives a notice of hearing under subsection (c) of this section shall, within 20 days of the date on which the notice of hearing is provided to the party, file a written answer or other responsive pleading. Such response shall be filed in accordance with 1 TAC §155.101 of this title (relating to Filing Documents) and §155.103 of this title (relating to Service of Documents on Parties).

(e) For purposes of this section, events described in paragraphs (1) or (2) of this subsection constitute a default on the part of a charged party who receives a notice of hearing under subsection (c) of this section:

(1) failure of the charged party to file a written response as provided by subsection (d) of this section; or

(2) failure of the charged party to appear in person or by legal representative on the day and at the time set for hearing in a contested case at SOAH, regardless of whether a written response has been filed.

(f) In the event that a charged party defaults as described by subsection (e) of this section, the division may seek informal disposition by default by the commissioner as permitted by Government Code §2001.056.

(g) For purposes of this subchapter, "disposition by default" shall mean the issuance of an order against the charged party in which the allegations against the party in the notice of hearing are deemed admitted as true, upon the offer of proof to the commissioner that proper notice was provided to the defaulting party. For purposes of this section, proper notice means notice sufficient to meet the provisions of the Government Code §2001.051 and §2001.052 and §148.5 of this title (relating to Notice of Hearing).

(h) After informal disposition of a contested case by default, a charged party may file a written motion to set aside the default order and reopen the record. A motion by the charged party to set aside the default order and reopen the record shall be granted by the commissioner if the charged party establishes that the failure to file a written response or to attend the hearing was neither intentional nor the result of conscious indifference, and that such failure was due to a mistake or accident. A motion to set aside the default order and reopen the record shall be filed by the charged party with the division's chief clerk of proceedings prior to the time that the order of the commissioner becomes final pursuant to the applicable provisions of Government Code, Chapter 2001, Subchapter F.

(i) A motion to set aside the default order and reopen the record is not a motion for rehearing and is not to be considered a substitute for a motion for rehearing. A motion for rehearing is required in order to exhaust administrative remedies. The filing of a motion to set aside the default order and reopen the record has no effect on either the statutory time periods for the filing of a motion for rehearing or on the time period for ruling on a motion for rehearing, as provided in applicable provisions of the Government Code, Chapter 2001, Subchapter F.

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

Filed with the Office of the Secretary of State on December 27, 2018.

TRD-201805567
Nicholas Canaday III
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: January 16, 2019
Proposal publication date: November 2, 2018
For further information, please call: (512) 804-4703

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SUBCHAPTER B. MEDICAL BENEFIT REGULATION

28 TAC §180.26

Amended §180.26 is adopted under the authority of Labor Code §§402.00111, 402.00116, 402.00128, 402.061, 415.021, and 415.032. The adopted amendments support the implementation of the Workers' Compensation Act, Labor Code Title 5, Subtitle A.

Labor Code §402.00111 states that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Texas Workers' Compensation Act.

Labor Code §402.00116 states that the commissioner of workers' compensation is DWC's chief executive and administrative officer and shall administer and enforce the Texas Workers' Compensation Act, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner of workers' compensation.

Labor Code §402.00128 states that the commissioner of workers' compensation shall conduct the daily operations of DWC and otherwise implement policy and, among other functions, may delegate, assess, and enforce penalties; and enter appropriate orders.

Labor Code §402.061 states that the commissioner shall adopt rules, as necessary, for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §415.021 states that the commissioner shall adopt rules that require DWC, in the assessment of an administrative penalty against a person, to communicate to the person information about the penalty, including the relevant statute or rule violated, the conduct that gave rise to the violation, and the factors considered in determining the penalty.

Labor Code §415.032 states that if an investigation by DWC indicates that an administrative violation has occurred, DWC shall notify the person alleged to have committed the violation in writing of various items including the charge. This statute also states steps the person alleged is required to take before the 20th day the noticed was received.

§180.26. Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies.

(a) The division may impose sanctions on any system participant if that system participant commits an administrative violation.

(b) The division may impose the following sanctions against a doctor or insurance carrier for any reason listed in Labor Code §408.0231(c) or any other criteria the commissioner considers relevant:

(1) reduction of allowable reimbursement to a doctor (such as an automatic percentage reduction on all or some types of health care);

(2) mandatory preauthorization or utilization review of all or certain health care treatments and services (such as mandatory treatment plans);

(3) required supervision or peer review monitoring, reporting, and audit (by the insurance carrier, the division, or an independent auditor or reviewer);

(4) deletion or suspension from the designated doctor list;

(5) restrictions on appointments or reviews;

(6) conditions or restrictions on an insurance carrier regarding actions by insurance carriers under the Act and rules, that are not inconsistent with a memorandum of understanding adopted between the commissioner and the commissioner of insurance regarding the regulation of insurance carriers and utilization review agents as necessary to ensure that appropriate health care decisions are reached under applicable regulations by the department and the division, the Act, and Chapter 4201, Insurance Code; and

(7) mandatory participation in training classes or other courses as established or certified by the division.

(c) In addition to a penalty or the other sanctions that may be imposed in accordance with other applicable provisions of the Act, the division may also impose the following sanctions pursuant to Labor Code §415.023(b) against an insurance carrier or its representative, a health care provider, or a representative of an injured employee or legal beneficiary if any of those parties commit an administrative violation as a matter of practice, meaning a repeated violation of the Act or a rule, order, or decision of the commissioner:

(1) a reduction or denial of fees;

(2) public or private reprimand by the commissioner;

(3) suspension from practice before the division;

(4) restriction, suspension, or revocation of the right to receive reimbursement under the Act; and

(5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

(d) In addition to, or in lieu of, the sanctions in subsections (b) and (c) of this section, the division may impose any other sanction or remedy allowed under the Act or division rules, including but not limited to assessing an administrative penalty of up to $25,000 per violation against a person who commits an administrative violation.

(e) When determining which sanction to impose against a system participant and the severity of that sanction, the division shall consider the factors listed in Labor Code §415.021(c) and other matters that justice may require, including but not limited to:

(1) Performance Based Oversight (PBO) assessment;

(2) the promptness and earnestness of actions to prevent future violations;

(3) self-report of the violation;

(4) the size of the company or practice;

(5) the effect of a sanction on the availability of health care; and

(6) evidence of heightened awareness of the legal duty to comply with the Act and division rules.

(f) In an investigation where both an administrative violation and a criminal prosecution are possible, the division may, at its discretion, postpone action on the administrative violation until the related criminal prosecution is completed.

(g) As an alternative to imposing a sanction such as an administrative penalty on a charged system participant, the division may, at its discretion, provide formal notice of the violation through a Warning Letter. A Warning Letter shall:

(1) include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill;

(2) identify the facts that establish that a violation occurred; and

(3) inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice, any of which will be subject to sanction.

(h) The division may enter into a consent order with the system participant if the division and the system participant have communicated regarding:

(1) the relevant statute or rule violated;

(2) the facts establishing that the administrative violation occurred; and

(3) the appropriateness of the proposed sanction, including how the division considered the factors under Labor Code §415.021(c) and subsection (e) of this section in determining the proposed sanction.

(i) A consent order may be entered into before or after issuance of an NOV under §180.8 of this title (relating to Notices of Violation; Notices of Hearing; Default Judgments). Consent orders must include:

(1) a description of which factors under Labor Code §415.021(c) and subsection (e) of this section the division considered aggravating or mitigating when determining the proposed sanction; and

(2) a statement that the system participant acknowledges:

(A) the division and the system participant communicated regarding the information listed in subsection (h)(1) - (3) of this section; and

(B) the division considered the factors under Labor Code §415.021(c) and subsection (e) of this section.

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

Filed with the Office of the Secretary of State on December 27, 2018.

TRD-201805568
Nicholas Canaday III
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: January 16, 2019
Proposal publication date: November 2, 2018
For further information, please call: (512) 804-4703

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 5. FUNDS MANAGEMENT (FISCAL AFFAIRS)

SUBCHAPTER E. CLAIMS PROCESSING--PURCHASE VOUCHERS

34 TAC §5.54, §5.57

The Comptroller of Public Accounts adopts amendments to §5.54, concerning consulting services contracts, and §5.57, concerning use of payment cards by state agencies, without changes to the proposed text as published in the October 19, 2018, issue of the *Texas Register* (43 TexReg 6941). The amended rules will not be republished in this issue of the *Texas Register.*

The amendments to §5.54 update the format of the definitions listed in subsection (a), without changing the substance of the definitions, so that they are presented in the same format as other definitions listed in Chapter 5; delete the definitions of consultant, executive director, and USAS in subsection (a)(1), (3), and (7), respectively, because these terms are no longer used in this section; add a definition of SPD in subsection (a), and change the references to Texas Procurement and Support Services and TPASS in subsection (e) to SPD, because the name of the division has changed to the Statewide Procurement Division; and update the legal citation listed in the definition of state agency in subsection (a)(6). These amendments also change "service" to "services" in subsection (d)(1)(A) and "paragraph" to "subsection" in subsection (f)(4) to correct typographical errors in this section.

The amendments to §5.57 update the format of the definitions listed in subsection (a), without changing the substance of the definitions, so that they are presented in the same format as other definitions listed in Chapter 5; delete the definition of TPASS in subsection (a)(1) because this term will no longer be used in this section; change the references to TPASS and institutions of higher education in subsections (e), (e)(1), and (h) to the comptroller to clarify that the comptroller has the authority to procure payment card services and adopt purchasing requirements for state agencies; and delete subsection (a)(2), (3), and (4) to reflect the comptroller's policy that the authority to contract with a payment card issuer on behalf of another state agency will not be delegated.

No comments were received regarding adoption of the amendments.

Section 5.54 is adopted under Government Code, §2254.039(a), which requires the comptroller to adopt rules to implement and administer Government Code, Chapter 2254, Subchapter B, concerning consulting services. The comptroller has given the amendments to §5.54 to the governor for review and comment as required by Government Code, §2254.039(b). Section 5.57 is adopted under Government Code, §403.023(b), which authorizes the comptroller to "adopt rules relating to the use of credit or charge cards by state agencies to pay for purchases."

Section 5.54 implements Government Code, Chapter 2254, Subchapter B, concerning consulting services. Section 5.57 implements Government Code, §403.023, concerning credit, charge, and debit cards.

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

Filed with the Office of the Secretary of State on December 20, 2018.

TRD-201805548

Victoria North
Chief Counsel, Fiscal and Agency Affairs Legal Services Division
Comptroller of Public Accounts
Effective date: January 9, 2019
Proposal publication date: October 19, 2018
For further information, please call: (512) 475-2220

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Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 16 TAC §25.505(f)(4)

∑((RTEP - POC) * (number of minutes in a settlement interval / 60 minutes per hour)) for each settlement interval when RTEP - POC >0.

Figure: 25 TAC §289.232(d)(20)

$$C = \frac{s}{\overline{X}} = \frac{1}{\overline{X}}\left[\sum_{i=1}^{n}\frac{(X_i - \overline{X})^2}{n-1}\right]^{1/2}$$

$$where: s = estimated\ standard\ deviation\ of\ the\ population$$

$$\overline{X} = mean\ value\ of\ observations\ in\ sample$$

$$X_i = ith\ observation\ in\ sample$$

$$n = number\ of\ observations\ in\ sample$$

Figure: 25 TAC §289.232(j)(4)(A)

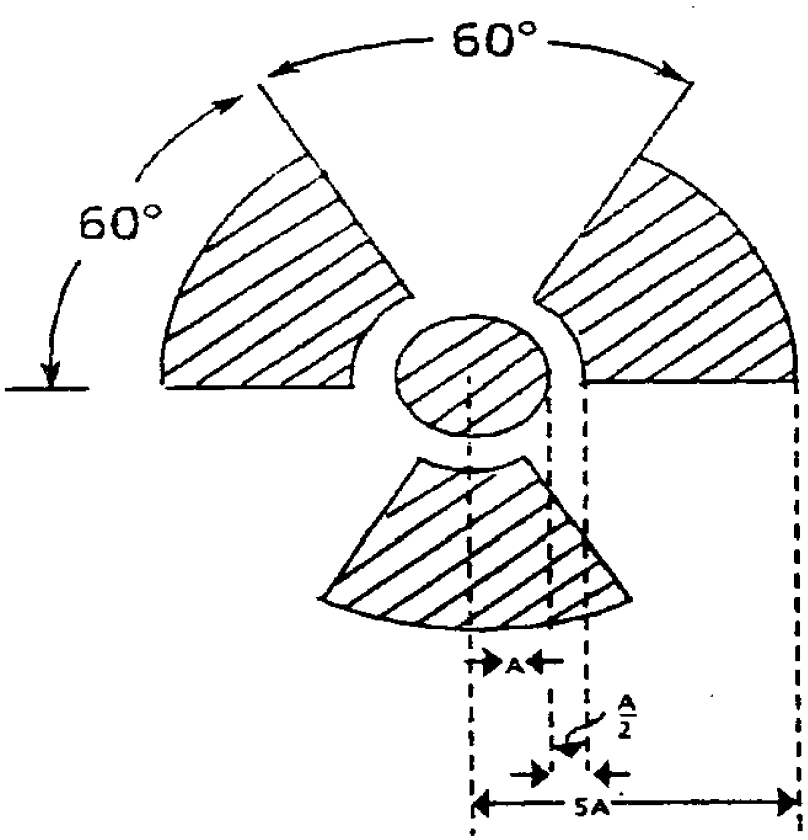

Figure: 25 TAC §289.232(j)(4)(B)(i)(I) RC FORM 232-1

Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347

NOTICE TO EMPLOYEES

TEXAS REGULATIONS FOR CONTROL OF RADIATION

The Department of State Health Services has established standards for your protection against radiation hazards, in accordance with the Texas Radiation Control Act, Health and Safety Code, Chapter 401.

YOUR EMPLOYER'S RESPONSIBILITY

Your employer is required to-
1. Apply these rules to work involving sources of radiation.
2. Post or otherwise make available to you a copy of the Department of State Health Services rules, certificates of registration, notices of violations, and operating procedures that apply to your work, and explain their provisions to you.

YOUR RESPONSIBILITY AS A WORKER

You should familiarize yourself with those provisions of the rules and the operating procedures that apply to your work. You should observe the rules for your own protection and protection of your co-workers.

WHAT IS COVERED BY THESE RULES

1. Limits on exposure to sources of radiation in restricted and unrestricted areas;
2. Measures to be taken after accidental exposure;
3. Individual monitoring devices, surveys, and equipment;
4. Caution signs, labels, and safety interlock equipment;
5. Exposure records and reports;
6. Options for workers regarding agency inspections; and
7. Related matters.

REPORTS ON YOUR RADIATION EXPOSURE HISTORY

1. The rules require that your employer give you a written report if you receive an exposure in excess of any applicable limit set forth in the rules or in the certificate of registration. The basic limits for exposure to employees are set forth in 25 Texas Administrative Code (TAC) §289.232(i)(4)(A) - (C) of this title (relating to Radiation Control Regulations for Dental Radiation Machines.) This subsection specifies limits on exposure to radiation.

2. If you work where individual monitoring devices are provided in accordance with 25 TAC §289.231 of this title (relating to General Provisions and Standards for Protection Against Machine-Produced Radiation);

(a) your employer shall furnish to you an annual written report of your exposure to radiation if.
  (1) the individual's occupational dose exceeds 100 mrem (1 mSv) total effective dose equivalent or 100 mrem (1 mSv) to any individual organ or tissue; or
  (2) the individual requests his or her annual dose report in writing.
(b) your employer shall give you a written report, upon termination of your employment, of your radiation exposures if you request the information on your radiation exposure in writing.

INSPECTIONS

All licensed or registered activities are subject to inspection by representatives of the Department of State Health Services. In addition, any worker or representative of the workers, who believes that there is a violation of the Texas Radiation Control Act, the rules issued thereunder, or the terms of the employer's license or registration with regard to radiological working conditions in which the worker is engaged, may request an inspection by sending a notice of the alleged violation to the Department of State Health Services. The request shall state the specific grounds for the notice, and shall be signed by the worker or the representative of the workers. During inspections, agency inspectors may confer privately with workers, and any worker may bring to the attention of the inspectors any past or present condition that the individual believes contributed to or caused any violations as described above.

POSTING REQUIREMENTS

Copies of this notice shall be posted in a sufficient number of places in every establishment where employees are employed in activities registered, in accordance with 25 TAC §289.232 (relating to Radiation Control Regulations for Dental Radiation Machines), to permit employees to observe a copy on the way to or from their place of employment.

Applicable section of 25 TAC Chapter 289 may be viewed online, at www.dshs.texas.gov/radiation. Our license and/or certificate of registration and any associated documents, our operation procedures, and any "Notice of Violation" or order issued by the agency may be viewed at the following location: _____

Figure: 25 TAC §289.232(j)(5)(E)(i)(I)

HALF-VALUE LAYER FOR SELECTED kVp

X-ray Tube Voltage (kilovolt peak)	Minimum HVL (mm of aluminum)

Designed operating range	Measured operating potential	Intraoral dental systems manufactured before or on June 10, 2006	Intraoral dental systems manufactured after June 10, 2006
Below 51	30	0.3	1.5
	40	0.4	1.5
	50	0.5	1.5
51 to 70	51	1.2	1.5
	60	1.3	1.5
	70	1.5	1.5
Above 70	71	2.1	2.1
	80	2.3	2.3
	90	2.5	2.5
	100	2.7	2.7
	110	3.0	3.0
	120	3.2	3.2
	130	3.5	3.5
	140	3.8	3.8
	150	4.1	4.1

Figure: 25 TAC §289.232(j)(5)(J)(ii)

Type of Machine	Frequency
CBCT	Annually not to exceed 14 months from the prior EPE
All other Dental X-ray	Four years from the date of prior EPE

Figure: 25 TAC §289.232(j)(5)(J)(x)

RADIOGRAPHIC ENTRANCE EXPOSURE LIMITS (AIR KERMA LIMITS)

Examination	Kilovolt Peak	Exposure Limit (mR)	(Air Kerma Limit) (mGy)
Adult Intraoral	60 and above	450	(4.5)
Adult Intraoral	Less than 60	600	(6.0)

Figure: 25 TAC §289.232(k)(1)(K)(i)(II)

"INFORMATION FALLING WITHIN EXCEPTION OF THE TEXAS PUBLIC INFORMATION ACT, GOVERNMENT CODE, CHAPTER 552 ---- CONFIDENTIAL

This document contains information submitted to the Department of State Health Services, Radiation Control by

_____

(Name of Company)(Name of Submitter)

that is claimed to fall within the following exception to the Texas Public Information Act, Government Code, Chapter 552, Subchapter C _____

(Appropriate Subsection)

WITHHOLD FROM PUBLIC DISCLOSURE

_____

(Signature and Title)(Office)(Date)"

Figure: 25 TAC §289.232(k)(2)(A)

RECORDS RETENTION

	Name of Record/Document	Specific Rule Subsection	Time Interval for Keeping Record/Document
(i)	Inventory of all Radiation Machines Possessed	(i)(5)(I)	Until next routine on-site inspection
(ii)	Receipt, Transfer, and Disposal of Each Radiation Machine Possessed	(i)(5)(J)	Until termination of registration
(iii)	Current Operating and Safety Procedures Documentation that all staff who operate the radiation machine(s) have read this document	(j)(2) (j)(2)(A)	Until termination of registration Until next routine on-site inspection
(iv)	Current 25 TAC, §289.232 of this title	(j)(4)(B)(i)(II)(-a-)	Until termination of registration
(v)	Current Certificate of Registration	(j)(4)(B)(i)(II)(-b-)	Until termination of registration
(vi)	Notice of Violation From Last Inspection (if applicable)	(j)(4)(B)(i)(II)(-d-)	Until next routine on-site inspection
(vii)	Documentation of Corrections of any Violations	(j)(4)(B)(i)(II)(-d-)	Until next routine on-site inspection
(viii)	Records of machine corrections or repairs	(j)(5)(I)	Until next routine on-site inspection
(ix)	Equipment Performance Evaluations	(j)(5)(J)(iii)	10 years
(x)	United States Food and Drug Administration Variances	(j)(8)	Until transfer of machines or termination of registration
(xi)	Film Processing Records and Corrections	(j)(12)(F)	Until next routine on-site inspection
(xii)	Alternative Processing System Records	(j)(13)	Until next routine on-site inspection

	Name of Record/Document	Specific Rule Subsection	Time Interval for Keeping Record/Document
(xiii)	Digital Imaging Acquisition System Records	(j)(14)(A)(ii)(II)	Until next routine on-site inspection
(xiv)	Records at Additional Authorized Sites	(k)(1)(I)	While location is authorized on registration

Figure: 25 TAC §289.232(l)(3)(D)(iii)(II)

BASE ADMINISTRATIVE PENALTIES

Table A – Base Amounts

Type of User	Amount
All registrants	$5,000
Other persons not registered	$10,000

Table B – Percentage of Base Amounts Based on Severity Level of Violation

Severity Level	Percent of Amount Listed in Table A
I	100
II	80
III	50
IV	15
V	5


Texas

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §303.003 and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/31/18 - 01/06/19 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/31/18 - 01/06/19 is 18% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

TRD-201805569
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: December 27, 2018

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Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 1/07/19 - 1/13/19 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 1/07/19 - 1/13/19 is 18% for Commercial over $250,000.

The monthly ceiling as prescribed by §303.005 and §303.009[3] for the period of 1/01/19 - 1/31/19 is 18% or Consumer/Agricultural/Commercial credit through $250,000.

The monthly ceiling as prescribed by §303.005 and §303.009 for the period of 1/01/19 - 1/31/19 is 18% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

[3] For variable rate commercial transactions only.

TRD-201900004
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: January 2, 2019

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Employees Retirement System of Texas

Correction of Error

The Employees Retirement System of Texas published a contract award announcement in the January 4, 2019, issue of the *Texas Register* (44 TexReg 136). In that announcement, the ending date for the term of the contract was incorrectly stated. The correct ending date should be December 31, 2024. The corrected sentence should read as follows:

"The term of the contract began on December 13, 2018 and will extend through December 31, 2024, subject to the terms of the contract."

TRD-201805587

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ERS Infrastructure Consulting Services RFQ - Contract Award Announcement

This contract award announcement is being submitted by the Employees Retirement System of Texas (ERS) in relation to a contract award to provide infrastructure consulting services. The contractor's services will include assisting ERS on maintaining and monitoring an infrastructure investment strategy including development of a long-term infrastructure plan; market and investment analysis; portfolio monitoring and management; and training (Required Services).

The selected contractor is CBRE Caledon Capital Management Inc., 141 Adelaide Street West, Unit 1500, Toronto, Canada M5H 3L5. The value of the contract is estimated to be $5,150,000.00. The contract was executed on December 21, 2018, and will be for a term beginning January 24, 2019, and extending through January 23, 2025, subject to the terms of the contract.

Deliverables will be based on the Required Services and determined by ERS on an annual basis.

TRD-201805551
Gabrielle Schreiber
Director of Procurement and Contract Oversight
Employees Retirement System of Texas
Filed: December 21, 2018

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 12, 2019.** TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or incon-

sistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be received by 5:00 p.m. on **February 12, 2019.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission's enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on the AOs shall be submitted to the commission in writing.

(1) COMPANY: 7-ELEVEN, INCORPORATED dba 7-Eleven Store 40819; DOCKET NUMBER: 2018-1173-PST-E; IDENTIFIER: RN102346178; LOCATION: Orange Grove, Jim Wells County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to provide release detection for the pressurized piping associated with the underground storage tank system; PENALTY: $5,625; ENFORCEMENT COORDINATOR: Rahim Momin, (512) 239-2544; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(2) COMPANY: Aaliyah, LLC dba K K Food Mart; DOCKET NUMBER: 2018-1189-PST-E; IDENTIFIER: RN103731220; LOCATION: San Augustine, San Augustine County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to provide release detection for the pressurized piping associated with the underground storage tank system; PENALTY: $2,937; ENFORCEMENT COORDINATOR: Carlos Molina, (512) 239-2557; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(3) COMPANY: Alan Matysiak dba Long Point Corner Store; DOCKET NUMBER: 2018-0802-PST-E; IDENTIFIER: RN102273646; LOCATION: Karnack, Harrison County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $4,125; ENFORCEMENT COORDINATOR: Christopher Moreno, (254) 761-3038; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(4) COMPANY: Alto Frio Baptist Encampment, Incorporated; DOCKET NUMBER: 2018-1030-PWS-E; IDENTIFIER: RN103779195; LOCATION: Leakey, Real County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.42(c)(1) and §290.111(a)(2), by failing to provide a minimum treatment consisting of coagulation with direct filtration and adequate disinfection for groundwater under the direct influence of surface water; PENALTY: $2,250; ENFORCEMENT COORDINATOR: Ross Luedtke, (254) 761-3036; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(5) COMPANY: ARGYLE 5T RANCH, LLC; DOCKET NUMBER: 2018-1656-WQ-E; IDENTIFIER: RN109989210; LOCATION: Argyle, Denton County; TYPE OF FACILITY: construction site; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $875; ENFORCEMENT COORDINATOR: Caleb Olson, (817) 588-5856; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(6) COMPANY: Blanchard Refining Company LLC; DOCKET NUMBER: 2018-0307-AIR-E; IDENTIFIER: RN102535077; LOCATION: Texas City, Galveston County; TYPE OF FACILITY: petroleum refinery; RULES VIOLATED: 30 TAC §§101.20(3), 116.715(a), and 122.143(4), Federal Operating Permit (FOP) Number O1541, Special Terms and Conditions (STC) Number 23, Flexible Permit Numbers 47256 and PSDTX402M3, Special Conditions (SC) Number 1, and Texas Health and Safety Code (THSC), §382.085(b), by failing to prevent unauthorized emissions; 30 TAC §115.725(a)(1)(C) and §122.143(4), FOP Number O1541, STC Number 1.H, and THSC, §382.085(b), by failing to comply with the minimum oxygen content limit; 30 TAC §116.115(b)(2)(f) and (c) and §122.143(4), FOP Number O1541, STC Number 23, New Source Review (NSR) Permit Number 2612, SC Number 1, and THSC, §382.085(b), by failing to comply with the permitted hourly maximum allowable emissions rate; 30 TAC §116.115(c) and §122.143(4), FOP Number O1541, STC Number 23, NSR Permit Number 2612, SC Number 9, and THSC, §382.085(b), by failing to comply with the permitted emissions limit; 30 TAC §116.116(b)(1) and THSC, §382.085(b), by failing to comply with the permit representations for NSR Permit Number 2231; and 30 TAC §117.310(c)(1)(A) and THSC, §382.085(b), by failing to comply with the carbon monoxide concentration limit; PENALTY: $68,125; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $34,062; ENFORCEMENT COORDINATOR: David Carney, (512) 239-2583; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(7) COMPANY: Bless Retail Incorporated dba Tick Tock Grocery #9; DOCKET NUMBER: 2018-1243-PST-E; IDENTIFIER: RN101434017; LOCATION: Alvin, Brazoria County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.7(d)(1)(C) and (3), by failing to provide written notice to the agency of any change or additional information concerning the underground storage tank (UST) system within 30 days from the date of the occurrence of the change or addition; and 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the USTs in a manner which will detect a release at a frequency of at least once every 30 days; PENALTY: $3,251; ENFORCEMENT COORDINATOR: Rahim Momin, (512) 239-2544; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(8) COMPANY: Burlington Resources Oil & Gas Company LP; DOCKET NUMBER: 2018-0676-AIR-E; IDENTIFIER: RN106454655; LOCATION: Runge, Karnes County; TYPE OF FACILITY: oil and gas processing facility; RULES VIOLATED: 30 TAC §101.201(b) and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit a final record for a reportable emissions event no later than two weeks after the end of the emissions event; and 30 TAC §116.615(2), Standard Permit Registration Number 115326, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $2,438; ENFORCEMENT COORDINATOR: Amanda Diaz, (512) 239-2601; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(9) COMPANY: City of Corpus Christi; DOCKET NUMBER: 2018-0201-MWD-E; IDENTIFIER: RN101610186; LOCATION: Corpus Christi, Nueces County; TYPE OF FACILITY: wastewater treatment facility; RULES VIOLATED: 30 TAC §305.62(a) and §305.125(1) and (8), and Texas Pollutant Discharge Elimination (TPDES) Permit Number WQ0010401005, Permit Conditions

Numbers 2.e and 2.g, by failing to obtain authorization from the commission before beginning any change in the permitted facility or activity which may result in noncompliance with any permit requirement; 30 TAC §305.125(1) and §319.11(b), and TPDES Permit Number WQ0010401005, Monitoring and Reporting Requirements Number 2.a, by failing to properly analyze effluent samples; 30 TAC §305.125(1) and §319.11(d), and TPDES Permit Number WQ0010401005, Operational Requirements Number 1, by failing to install flow measurement devices in accordance with the Water Measurement Manual, United States Department of the Interior, Bureau of Reclamation, Washington D.C., or methods that are equivalent as approved by the executive director; and 30 TAC §305.125(1) and TPDES Permit Number WQ0010401005, Operational Requirements Number 1, by failing to ensure at all times that the facility and all of its systems of collection, treatment, and disposal are properly operated and maintained; PENALTY: $19,689; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $15,752; ENFORCEMENT COORDINATOR: Sandra Douglas, (512) 239-2549; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(10) COMPANY: City of Luling; DOCKET NUMBER: 2018-1122-PWS-E; IDENTIFIER: RN101219301; LOCATION: Gonzales, Gonzales County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.42(l), by failing to provide a thorough and up-to-date plant operations manual for operator review and reference; 30 TAC §290.46(f)(2) and (3)(A)(iv), by failing to maintain water works operation and maintenance records and make them readily available for review by commission personnel during the investigation; 30 TAC §290.46(m)(1)(A), by failing to conduct an annual inspection of the facility's ground storage tank; 30 TAC §290.46(s)(2)(C)(i), by failing to verify the accuracy of the manual disinfectant residual analyzer at least once every 90 days using chlorine solutions of known concentrations; 30 TAC §290.110(f)(1)(B), by failing to ensure that all samples used for compliance are obtained at sampling sites designated in the monitoring plan; and 30 TAC §290.121(a) and (b), by failing to maintain an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations, describes the sampling frequency, and specifies the analytical procedures and laboratories that the public water system will use to comply with the monitoring requirements; PENALTY: $640; ENFORCEMENT COORDINATOR: Ryan Byer, (512) 239-2571; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(11) COMPANY: COUNTRY TERRACE WATER COMPANY, INCORPORATED; DOCKET NUMBER: 2018-0903-MLM-E; IDENTIFIER: RN101282010; LOCATION: Highlands, Harris County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.45(b)(1)(D)(iii) and (f)(5) and Texas Health and Safety Code (THSC), §341.0315(c), by failing to provide two or more service pumps having a total capacity of 2.0 gallons per minute per connection; 30 TAC §290.45(b)(1)(D)(iv) and THSC, §341.0315(c), by failing to provide a pressure tank capacity of 20 gallons per connection; 30 TAC §290.45(h)(1)(D), by failing to provide one of the options of sufficient power to meet capacity requirements and in accordance with the affected utility's emergency preparedness plan; 30 TAC §290.46(j), by failing to complete a customer service inspection certificate prior to providing continuous service to new construction or any existing service when the water purveyor has reason to believe cross-connections or other potential contamination hazards exists; 30 TAC §290.46(l), by failing to flush all dead-end mains at monthly intervals; 30 TAC §290.46(z), by failing to create a nitrification action plan for a system distributing chloraminated water; and 30 TAC §291.93(3) and TWC, §13.139(d), by failing to submit to the executive director a planning report that clearly explains how the retail public utility will provide the expected service demand to the remaining areas within the boundaries of its certificated area when the facility has reached 85% of its capacity; PENALTY: $3,100; ENFORCEMENT COORDINATOR: Ryan Byer, (512) 239-2571; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(12) COMPANY: Day to Day Operations, LLC dba Stars; DOCKET NUMBER: 2018-1258-PST-E; IDENTIFIER: RN104525324; LOCATION: Orange, Orange County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.10(b)(1)(B), by failing to assure that all underground storage tank recordkeeping requirements are met; and 30 TAC §334.50(d)(1)(B)(ii) and (iii)(I) and TWC, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records at least once every 30 days, in a manner sufficiently accurate to detect a release as small as the sum of 1.0% of the total substance flow-through for the 30-day period plus 130 gallons, and failing to record inventory volume measurement for regulated substance inputs, withdrawals, and the amount still remaining in the tank each operating day; PENALTY: $6,200; ENFORCEMENT COORDINATOR: Ken Moller, (512) 239-6111; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(13) COMPANY: DCP Operating Company, LP; DOCKET NUMBER: 2018-1385-AIR-E; IDENTIFIER: RN101980027; LOCATION: Spearman, Hansford County; TYPE OF FACILITY: natural gas compression station; RULES VIOLATED: 30 TAC §106.6(b), Permit by Rule Registration Number 73989, and Texas Health and Safety Code, §382.085(b), by failing to comply with all representations with regard to construction plans, operating procedures, and maximum emission rates in any certified registration; PENALTY: $2,625; ENFORCEMENT COORDINATOR: Rebecca Johnson, (361) 825-3424; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(14) COMPANY: DIAMOND SHAMROCK REFINING COMPANY, L.P.; DOCKET NUMBER: 2018-1288-AIR-E; IDENTIFIER: RN100542802; LOCATION: Three Rivers, Live Oak County; TYPE OF FACILITY: petroleum refinery; RULES VIOLATED: 30 TAC §122.143(4) and §122.146(2), Federal Operating Permit Number O1450, General Terms and Conditions and Special Terms and Conditions Number 25, and Texas Health and Safety Code, §382.085(b), by failing to submit a permit compliance certification no later than 30 days after the end of the certification period; PENALTY: $2,813; ENFORCEMENT COORDINATOR: Steven Hall, (512) 239-2569; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(15) COMPANY: DRIVER LEASING, INCORPORATED; DOCKET NUMBER: 2018-1343-PST-E; IDENTIFIER: RN106870884; LOCATION: Amarillo, Potter County; TYPE OF FACILITY: fleet refueling facility; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of a petroleum underground storage tank (UST) system; 30 TAC §334.7(d)(3) and §334.8(c)(4)(A) and (C), by failing to obtain a UST delivery certificate by submitting a properly completed UST registration and self-certification form to TCEQ within 30 days of the change in ownership and the UST delivery certificate was not renewed annually; 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the UST system; 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the UST system; 30 TAC §334.50(b)(1)(A) and

TWC, §26.3475(c)(1), by failing to monitor the UST for releases at a frequency of at least once every 30 days; 30 TAC §334.51(b)(2)(C) and TWC, §26.3475(c)(2), by failing to equip each tank with a valve or other device designed to automatically shut off the flow of regulated substances into the tank when the liquid level in the tank reaches no higher than 95% capacity; and 30 TAC §334.602(a), by failing to identify and designate for the UST facility at least one named individual for each class of operator - Class A, Class B, and Class C; PENALTY: $17,929; ENFORCEMENT COORDINATOR: Carlos Molina, (512) 239-2557; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(16) COMPANY: ECOWATER INDUSTRIES, LLC; DOCKET NUMBER: 2017-0117-IHW-E; IDENTIFIER: RN100594530; LOCATION: Port Arthur, Jefferson County; TYPE OF FACILITY: commercial recycling facility; RULES VIOLATED: 30 TAC §335.2(n), by failing to obtain a permit for discharging industrial solid waste (ISW) to a Publicly Owned Treatment Works; 30 TAC §335.6(c), by failing to update the facility's Notice of Registration; 30 TAC §335.9(a)(1), by failing to maintain records of all hazardous and ISW activities; 30 TAC §335.70(a) and §335.513(c) and 40 Code of Federal Regulations (CFR) §262.11(f), by failing to maintain records of any test results, waste analysis, or other determinations made in accordance with 30 TAC §335.62 for at least three years from the date that the waste was last sent to an on-site or off-site storage, processing, or disposal facility; 30 TAC §335.69(a)(1)(A) and 40 CFR §265.173(a), by failing to keep a container holding hazardous waste closed except when adding or removing waste; and 30 TAC §335.69(d)(2), by failing to label a hazardous waste container with the words "Hazardous Waste" or with other words that identify the contents of the containers; PENALTY: $9,726; ENFORCEMENT COORDINATOR: Jonathan Nguyen, (512) 239-1661; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(17) COMPANY: Enterprise Refined Products Company LLC; DOCKET NUMBER: 2018-1232-AIR-E; IDENTIFIER: RN100219591; LOCATION: Baytown Terminal, Harris County; TYPE OF FACILITY: petroleum terminal; RULES VIOLATED: 30 TAC §122.143(4) and §122.146(1) and (2), Federal Operating Permit Number O2725, General Terms and Conditions and Special Terms and Conditions Number 15, and Texas Health and Safety Code, §382.085(b), by failing to certify compliance with the terms and conditions of the permit for at least each 12-month period following initial permit issuance, and failing to submit a permit compliance certification no later than 30 days after the end of the certification period; PENALTY: $2,438; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $975; ENFORCEMENT COORDINATOR: Carol McGrath, (210) 403-4063; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(18) COMPANY: Exxon Mobil Corporation; DOCKET NUMBER: 2018-0505-AIR-E; IDENTIFIER: RN102579307; LOCATION: Baytown, Harris County; TYPE OF FACILITY: petroleum refinery; RULES VIOLATED: 30 TAC §§101.20(3), 116.715(a), and 122.143(4), Federal Operating Permit (FOP) Number O1229, Special Terms and Conditions (STC) Number 32, Flexible Permit Numbers 18287, PSDTX730M4, and PAL7, Special Conditions Number 1, and Texas Health and Safety Code (THSC), §382.085(b), by failing to prevent unauthorized emissions; and 30 TAC §101.201(b)(1)(G) and §122.143(4), FOP Number O1229, STC Number 2.F, and THSC, §382.085(b), by failing to identify the compounds or mixtures of air contaminants from all emissions points involved in the emissions event on the final record for a reportable emissions event; PENALTY: $13,330; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $5,332; ENFORCEMENT COORDINATOR: Johnnie Wu, (512) 239-2524; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(19) COMPANY: Grand Texas Homes, Incorporated; DOCKET NUMBER: 2018-1722-WQ-E; IDENTIFIER: RN110521911; LOCATION: Parker, Collin County; TYPE OF FACILITY: construction site; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $875; ENFORCEMENT COORDINATOR: Aaron Vincent, (512) 239-0855; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(20) COMPANY: Gulf South Pipeline Company, LP; DOCKET NUMBER: 2018-1132-AIR-E; IDENTIFIER: RN108443706; LOCATION: Boling-Iago, Wharton County; TYPE OF FACILITY: gas compression site; RULES VIOLATED: 30 TAC §122.143(4) and §122.146(1) and (2), Federal Operating Permit (FOP) Number O3808/General Operating Permit (GOP) Number 514, Site-wide Requirements (b)(3), and Texas Health and Safety Code (THSC), §382.085(b), by failing to certify compliance with the terms and conditions of the permit for at least each 12-month period following initial permit issuance, and failing to submit the permit compliance certification no later than 30 days after the end of the certification period; and 30 TAC §122.143(4) and §122.145(2)(B) and (C), FOP Number O3808/GOP Number 514, Site-wide Requirements (b)(2), and THSC, §382.085(b), by failing to submit a deviation report for at least each six-month period after permit issuance, and failing to submit the deviation report no later than 30 days after the end of each reporting period; PENALTY: $11,250; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $4,500; ENFORCEMENT COORDINATOR: Amanda Diaz, (512) 239-2601; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(21) COMPANY: J & S Materials, LLC; DOCKET NUMBER: 2018-1689-WQ-E; IDENTIFIER: RN109250217; LOCATION: Schertz, Bexar County; TYPE OF FACILITY: mining site; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a multi-sector general permit; PENALTY: $875; ENFORCEMENT COORDINATOR: Christopher Moreno, (254) 761-3038; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(22) COMPANY: Jesus Matamoros dba Texas Truck Wash; DOCKET NUMBER: 2018-1177-WQ-E; IDENTIFIER: RN101612489; LOCATION: El Paso, El Paso County; TYPE OF FACILITY: commercial truck washing facility; RULES VIOLATED: 30 TAC §305.42(a), by failing to obtain authorization under TCEQ General Permit Number WQG100000 to dispose of wastewater by evaporation from surface impoundments adjacent to water in the state; PENALTY: $10,625; ENFORCEMENT COORDINATOR: Aaron Vincent, (512) 239-0855; REGIONAL OFFICE: 401 East Franklin Avenue, Suite 560, El Paso, Texas 79901-1212, (915) 834-4949.

(23) COMPANY: Midland County; DOCKET NUMBER: 2018-1245-WQ-E; IDENTIFIER: RN105577951; LOCATION: Midland, Midland County; TYPE OF FACILITY: small municipal separate storm sewer system; RULES VIOLATED: 30 TAC §281.25(a)(4), TWC, §26.121(a), and 40 Code of Federal Regulations §122.26(a)(9)(i)(A), by failing to maintain authorization to discharge stormwater under Texas Pollutant Discharge Elimination System General Permit for Small Municipal Separate Storm Sewer Systems; PENALTY: $21,250; ENFORCEMENT COORDINATOR: Claudia Corrales, (432) 620-6138; REGIONAL OFFICE: 9900 West IH-20, Suite 100, Midland, Texas 79706, (432) 570-1359.

(24) COMPANY: NEW MUBIN, LLC dba Star Stop 6; DOCKET NUMBER: 2018-1228-PST-E; IDENTIFIER: RN101728624; LOCATION: Orange, Orange County; TYPE OF FACILITY: gasoline dispensing facility; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and

(2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tanks (USTs) in a manner which will detect a release at a frequency of at least once every 30 days, and failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $2,934; ENFORCEMENT COORDINATOR: Marla Waters, (512) 239-4712; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(25) COMPANY: PCI Nitrogen, LLC; DOCKET NUMBER: 2017-1422-AIR-E; IDENTIFIER: RN101621944; LOCATION: Pasadena, Harris County; TYPE OF FACILITY: fertilizer manufacturing plant; RULES VIOLATED: 30 TAC §101.201(a)(1)(B) and §122.143(4), Federal Operating Permit (FOP) Number O1252, General Terms and Conditions (GTC) and Special Terms and Conditions (STC) Number 2.F, and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit an initial notification for a reportable emissions event within 24 hours after discovery; 30 TAC §101.201(b)(1)(H) and §122.143(4), FOP Number O1252, GTC and STC Number 2.F, and THSC, §382.085(b), by failing to report the estimated total quantities of compounds released during an emissions event; and 30 TAC §116.115(c) and §122.143(4), New Source Review Permit Number 4209A, Special Conditions Number 1, FOP Number O1252, GTC and STC Number 12, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $7,951; ENFORCEMENT COORDINATOR: Trina Grieco, (210) 403-4006; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(26) COMPANY: Pure Utilities, L.C.; DOCKET NUMBER: 2018-1403-PWS-E; IDENTIFIER: RN101256998; LOCATION: Livingston, Tyler County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.108(f)(1) and Texas Health and Safety Code, §341.0315(c), by failing to comply with the maximum contaminant level (MCL) of 15 picoCuries per liter (pCi/L) for gross alpha particle activity, based on the running annual average, and failing to comply with the MCL of 5 pCi/L for combined radium-226 and radium-228, based on the running annual average; PENALTY: $1,462; ENFORCEMENT COORDINATOR: Julianne Dewar, (512) 239-1001; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(27) COMPANY: RBTQ, INCORPORATED; DOCKET NUMBER: 2018-1273-PWS-E; IDENTIFIER: RN101251775; LOCATION: Lubbock, Lubbock County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.42(e)(2), by failing to disinfect groundwater prior to distribution or storage in a manner consistent with the requirements of 30 TAC §290.110; 30 TAC §290.42(l), by failing to compile and maintain a thorough and up-to-date plant operations manual for operator review and reference; 30 TAC §290.46(d)(2)(A) and §290.110(b)(4) and Texas Health and Safety Code, §341.0315(c), by failing to maintain a disinfectant residual of at least 0.2 milligrams per liter (mg/L) of free chlorine in each finished water storage tank and throughout the distribution system at all times; 30 TAC §290.46(f)(2) and (3)(A)(i)(III) and (ii)(III) and (3)(B)(iii), (D)(i) and (ii), by failing to maintain water works operation and maintenance records and make them readily available for review by commission personnel during the investigation; 30 TAC §290.46(n)(2), by failing to provide an accurate and up-to-date map of the distribution system so that valves and mains can be easily located during emergencies; 30 TAC §290.121(a) and (b), by failing to maintain an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations, describes the sampling frequency, and specifies the analytical procedures and laboratories that the public water system will use to comply with the monitoring requirements and maintain a copy at each plant site; and 30 TAC §291.76 and TWC, §5.702, by failing to fully pay regulatory assessment fees for the TCEQ Public Utility Account regarding Certificate of Convenience and Necessity Number 12891 for calendar year 2017; PENALTY: $623; ENFORCEMENT COORDINATOR: Ryan Byer, (512) 239-2571; REGIONAL OFFICE: 5012 50th Street, Suite 100, Lubbock, Texas 79414-3426, (806) 796-7092.

(28) COMPANY: RIVER ROAD CAMP, INCORPORATED; DOCKET NUMBER: 2018-1206-PWS-E; IDENTIFIER: RN101285237; LOCATION: New Braunfels, Comal County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.45(c)(1)(B)(i) and Texas Health and Safety Code, §341.0315(c), by failing to provide a well capacity of 0.6 gallons per minute per connection; 30 TAC §290.46(n)(1), by failing to maintain accurate and up-to-date detailed as-built plans or record drawings and specifications for each treatment plant, pump station, and storage tank at the public water system until the facility is decommissioned; and 30 TAC §290.46(n)(3), by failing to keep on file copies of well completion data as defined in 30 TAC §290.41(c)(3)(A) for as long as the well remains in service; PENALTY: $200; ENFORCEMENT COORDINATOR: Yuliya Dunaway, (210) 403-4077; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(29) COMPANY: SAI SACHIN INC dba Glad Mart; DOCKET NUMBER: 2018-1056-PST-E; IDENTIFIER: RN102586658; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $3,375; ENFORCEMENT COORDINATOR: Ken Moller, (512) 239-6111; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(30) COMPANY: SKIDMORE STORE, LLC dba Papa's Market; DOCKET NUMBER: 2018-1159-PST-E; IDENTIFIER: RN102048618; LOCATION: Skidmore, Bee County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tanks (USTs) for releases at a frequency of at least once every 30 days, and failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $3,499; ENFORCEMENT COORDINATOR: Margarita Dennis, (817) 588-5892; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(31) COMPANY: Skip Sandell and Nancy Heaton; DOCKET NUMBER: 2018-1224-EAQ-E; IDENTIFIER: RN110412574; LOCATION: Georgetown, Williamson County; TYPE OF FACILITY: construction site; RULE VIOLATED: 30 TAC §213.4(a)(1), by failing to obtain approval of an Edwards Aquifer Protection Program plan prior to commencing regulated activity over the Edwards Aquifer Recharge Zone; PENALTY: $5,625; ENFORCEMENT COORDINATOR: Chase Davenport, (512) 239-2615; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 339-2929.

(32) COMPANY: SLA Business, Incorporated dba Express Mart; DOCKET NUMBER: 2018-1095-PST-E; IDENTIFIER: RN101889533; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $3,563; ENFORCEMENT COORDINATOR: Rahim Momin, (512) 239-2544; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(33) COMPANY: Stevens Trucking, Incorporated; DOCKET NUMBER: 2018-1349-WQ-E; IDENTIFIER: RN107095168; LOCATION: New Braunfels, Comal County; TYPE OF FACILITY: aggregate production operation (APO); RULES VIOLATED: 30 TAC §281.25(a)(4), and Texas Pollutant Discharge Elimination System General Permit Number TXR05DK24, Part III, Section A.1(a), by failing to ensure that all required records are maintained onsite and made readily available for review upon request; and 30 TAC §342.25(d), by failing to renew the APO registration annually as regulated activities continued; PENALTY: $6,000; ENFORCEMENT COORDINATOR: Chase Davenport, (512) 239-2615; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(34) COMPANY: Texas National Municipal Utility District; DOCKET NUMBER: 2018-1269-MWD-E; IDENTIFIER: RN102916749; LOCATION: Houston, Montgomery County; TYPE OF FACILITY: wastewater treatment facility; RULES VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a)(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0011715001, Interim I Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; PENALTY: $7,812; ENFORCEMENT COORDINATOR: Harley Hobson, (512) 239-1337; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(35) COMPANY: Texas Petroleum Group, LLC dba TPG 218 05; DOCKET NUMBER: 2018-1214-PST-E; IDENTIFIER: RN102849106; LOCATION: Humble, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.50(d)(1)(B)(ii) and TWC, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records at least once each month, in a manner sufficiently accurate to detect a release as small as the sum of 1.0% of the total substance flow-through for the month plus 130 gallons; 30 TAC §334.72, by failing to report a suspected release to the agency within 24 hours of discovery; and 30 TAC §334.74, by failing to investigate a suspected release of a regulated substance within 30 days of discovery; PENALTY: $48,000; ENFORCEMENT COORDINATOR: Berenice Munoz, (512) 239-2617; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(36) COMPANY: Texmark Chemicals, Incorporated; DOCKET NUMBER: 2018-1283-AIR-E; IDENTIFIER: RN100238740; LOCATION: Galena Park, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §122.143(4) and §122.145(2)(C), Texas Health and Safety Code (THSC), §382.085(b), and Federal Operating Permit (FOP) Number O1363, General Terms and Conditions (GTC), by failing to submit a semi-annual deviation report no later than 30 days after the end of the reporting period; and 30 TAC §122.143(4) and §122.146(2), THSC, §382.085(b), and FOP O1363, GTC and Special Terms and Conditions Number 17, by failing to submit a permit compliance certification no later than 30 days after the end of the certification period; PENALTY: $7,201; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $2,880; ENFORCEMENT COORDINATOR: Soraya Bun, (512) 239-2695; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(37) COMPANY: Utilities Investment Company, Incorporated; DOCKET NUMBER: 2018-1196-PWS-E; IDENTIFIER: RN101260669; LOCATION: Trinity, Walker County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.115(f)(1) and §290.122(b)(2)(A) and (f) and Texas Health and Safety Code, §341.0315(c), by failing to comply with the maximum contaminant level (MCL) of 0.080 milligrams per liter (mg/L) for total trihalomethanes (TTHM) based on the locational running annual average, and failing to provide public notification and submit a copy of the public notification, accompanied with a signed Certificate of Delivery, to the executive director regarding the failure to comply with the MCL of 0.080 mg/L for TTHM during the first quarter of 2018; PENALTY: $175; ENFORCEMENT COORDINATOR: Christopher Moreno, (254) 761-3038; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(38) COMPANY: WestRock Texas, L.P.; DOCKET NUMBER: 2018-1346-AIR-E; IDENTIFIER: RN102157609; LOCATION: Evadale, Jasper County; TYPE OF FACILITY: pulp and paper mill; RULES VIOLATED: 30 TAC §§101.20(3), 116.115(c), and 122.143(4), New Source Review Permit Numbers 20365 and PSDTX785M7, Special Conditions Number 1, Federal Operating Permit Number O1265, General Terms and Conditions and Special Terms and Conditions Number 14, and Texas Health and Safety Code, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $4,463; ENFORCEMENT COORDINATOR: Carol McGrath, (210) 403-4063; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

TRD-201900003
Charmaine Backens
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 2, 2019

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Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 12, 2019.** TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on February 12, 2019.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorneys are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: Green Mobile Home Park, Inc.; DOCKET NUMBER: 2016-0652-MLM-E; TCEQ ID NUMBER: RN101242584;

LOCATION: 11410 University Avenue, Lubbock, Lubbock County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.43(d)(2), by failing to provide each pressure tank with a pressure release device and an easily readable pressure gauge; 30 TAC §290.43(e), by failing to ensure that potable water storage tanks and pressure maintenance facilities are installed in a lockable building that is designed to prevent intruder access or enclosed by an intruder-resistant fence with lockable gates; 30 TAC §290.121(a) and (b), by failing to develop and maintain an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations, describes the sampling frequency, and specifies the analytical procedures and laboratories that the facility will use to comply with the monitoring requirements; 30 TAC §290.46(f)(2) and (3)(A)(ii)(III), by failing to maintain water works operation and maintenance records and make them readily available for review by the executive director upon request; 30 TAC §290.46(n)(2), by failing to provide an accurate and up-to-date map of the distribution system so that valves and mains can be easily located during emergencies; 30 TAC §290.46(s)(1), by failing to calibrate the facility's well meter at least once every three years; 30 TAC §290.39(l) and §290.42(g), by failing to obtain approval for an exception to utilize an innovative/alternative treatment process; 30 TAC §290.110(d)(1), by failing to have free chlorine reagents for the color comparator used to measure the free chlorine residual; and TWC, §26.121(a) and 30 TAC §290.42(i) and §305.42(a), by failing to obtain authorization from the commission prior to any discharge of wastewater; PENALTY: $2,398; STAFF ATTORNEY: Ryan Rutledge, Litigation Division, MC 175, (512) 239-0630; REGIONAL OFFICE: Lubbock Regional Office, 5012 50th Street, Suite 100, Lubbock, Texas 79414-3426, (806) 796-7092.

(2) COMPANY: PRAIRIE GROVE WATER SUPPLY CORPORATION; DOCKET NUMBER: 2017-1167-PWS-E; TCEQ ID NUMBER: RN101459758; LOCATION: 3436 Farm-to-Market Road 1818 near Diboll, Angelina County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.271(b) and §290.274(a) and (c), by failing to mail or directly deliver one copy of the Consumer Confidence Report (CCR) to each bill paying customer by July 1st of each year, and failing to submit to the TCEQ by July 1st of each year a copy of the annual CCR and certification that the CCR has been distributed to the customers of the facility and that the information in the CCR is correct and consistent with compliance monitoring data; 30 TAC §§290.272, 290.273, and 290.274(a) and (c), by failing to meet the adequacy, availability, and/or content requirements for the CCR; Texas Health and Safety Code, §341.0315(c), 30 TAC §290.115(f)(1), and TCEQ AO Docket Number 2014-0128-PWS-E, Ordering Provision Number 2.d.ii., by failing to comply with the maximum contaminant level (MCL) of 0.080 milligrams per liter for total trihalomethanes (TTHM) based on the locational running annual average; 30 TAC §290.117(c)(2)(A), (h), and (i)(1) and §290.122(c)(2)(A) and (f), by failing to collect lead and copper tap samples at the required 20 sample sites, have the samples analyzed, and report the results to the executive director (ED) within ten days following the end of the monitoring period, and failing to provide public notification and submit a copy of the public notification to the ED regarding the failure to collect lead and copper tap samples; 30 TAC §290.117(c)(2)(B), (h), and (i)(1) and §290.122(c)(2)(A) and (f), by failing to collect lead and copper tap samples at the required ten sample sites, have the samples analyzed, and report the results to the ED within ten days following the end of the monitoring period, and failing to provide public notification and submit a copy of the public notification to the ED regarding the failure to collect lead and copper tap samples; 30 TAC §290.122(b)(2)(A) and (f), by failing to provide public notification and submit a copy of the public notification to the ED regarding the failure to comply with the MCL for TTHM; and 30 TAC §291.76 and TWC, §5.702, by failing to pay regulatory assessment fees for the TCEQ Public Utility Account regarding Certificate of Convenience and Necessity Number 10407; PENALTY: $2,205; STAFF ATTORNEY: Adam Taylor, Litigation Division, MC 175, (512) 239-3345; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(3) COMPANY: STAFF WATER SUPPLY CORPORATION; DOCKET NUMBER: 2018-0553-PWS-E; TCEQ ID NUMBER: RN101189918; LOCATION: at the 620 West Loop 254, Ranger, Eastland County; TYPE OF FACILITY: public water system; RULES VIOLATED: Texas Health and Safety Code, §341.0315(c) and 30 TAC §290.115(f)(1), by failing to comply with the maximum contaminant level of 0.080 milligrams per liter for total trihalomethanes, based on a locational running annual average; PENALTY: $486; STAFF ATTORNEY: Logan Harrell, Litigation Division, MC 175, (512) 239-1439; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

TRD-201900001
Charmaine Backens
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 2, 2019

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent the Executive Director's Preliminary Report and Petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 12, 2019.** The commission will consider any written comments received, and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on February 12, 2019.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on the DOs shall be submitted to the commission in **writing.**

(1) COMPANY: Country Stop, LLC.; DOCKET NUMBER: 2016-1376-PST-E; TCEQ ID NUMBER: RN102281417; LOCATION: 2610 Belle Plain Street, Brownwood, Brown County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide release detection for the pressurized piping associated with the UST system; and 30 TAC §334.10(b)(2), by failing to assure that all UST recordkeeping requirements were met; PENALTY: $6,637; STAFF ATTORNEY: John S. Merculief II, Litigation Division, MC 175, (512) 239-6944; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(2) COMPANY: ELM RIDGE WATER COMPANY, INC.; DOCKET NUMBER: 2015-0481-MLM-E; TCEQ ID NUMBER: RN101210672; LOCATION: 2040 Elm Ridge Drive, Spring Branch, Comal County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.46(n)(1), by failing to maintain accurate and up-to-date detailed as-built plans or record drawings and specifications for each treatment plant, pump station, and storage tank at the facility; 30 TAC §290.110(c)(4)(A) and TCEQ Agreed Order (AO) Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.a.ii., by failing to monitor the disinfectant residual at representative locations in the distribution system at least once every seven days; 30 TAC §290.46(v) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.b.vi., by failing to ensure that all electrical wiring is securely installed in compliance with a local or national electrical code; 30 TAC §290.41(c)(3)(K) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provisions Number 2.b.vii. and 2.b.viii., by failing to properly seal the wellhead with the use of gaskets or sealing compound, and to screen the well casing vent with an opening that is covered with a 16-gauge mesh or finer corrosion resistant screen, facing downward, elevated and located so as to minimize the drawing of contaminants into the well; 30 TAC §290.43(c)(2) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.b.x., by failing to provide the facility's ground storage tank with a roof hatch that remains locked except during inspections and maintenance; 30 TAC §290.46(s)(1) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.b.xi., by failing to calibrate the facility's well meter at least once every three years; Texas Health and Safety Code (THSC), §341.033(a), 30 TAC §290.46(e)(4)(A), and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.b.xii., by failing to operate the facility under the direct supervision of a water works operator who holds a Class "D" or higher license; 30 TAC §290.46(f)(2), (3)(A)(i)(III), (ii)(III), and (iv), and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.b.xiii., by failing to maintain water works operation and maintenance records and make them available for review to commission personnel during the investigation; 30 TAC §290.43(c)(1) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.d.iii., by failing to provide the facility's ground storage tank with a goose neck vent or roof ventilator with an opening protected by a 16-gauge mesh or finer corrosion resistant screen to prevent entry of animals, birds, insects, and heavy air contaminants; 30 TAC §290.42(l) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.d.iv., by failing to maintain a thorough and up-to-date plant operator's manual for operator review and reference; 30 TAC §290.46(n)(2) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.d.vi., by failing to provide an accurate and up-to-date map of the distribution system so that valves and mains can be located during emergencies; 30 TAC §290.46(i) and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.f.i., by failing to adopt an adequate plumbing ordinance, regulations or service agreement with provisions for proper enforcement to ensure that neither cross-connections nor other unacceptable plumbing practices are permitted; THSC, §341.0315(c), 30 TAC §290.45(b)(1)(B)(i), and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.h., by failing to provide a minimum well capacity of 0.6 gallons per minute per connection; 30 TAC §290.46(m)(4), by failing to maintain all water treatment units, storage and pressure maintenance facilities, distribution lines, and related appurtenances in a watertight condition; and TWC, §11.1272(c), 30 TAC §288.20(a) and §288.30(5)(B), and TCEQ AO Docket Number 2013-0280-MLM-E, Ordering Provision Number 2.d.v., by failing to adopt a Drought Contingency Plan which includes all elements for municipal use by a retail public water supplier; PENALTY: $15,759; STAFF ATTORNEY: Ryan Rutledge, Litigation Division, MC 175, (512) 239-0630; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(3) COMPANY: TEX-Q EXPRESS INC; DOCKET NUMBER: 2018-0361-MSW-E; TCEQ ID NUMBER: RN110061736; LOCATION: approximately 1.73 miles southeast of the intersection of Farm-to-Market Road 3463 and United States Highway 83, Menard, Menard County; TYPE OF FACILITY: trucking company; RULES VIOLATED: TWC, §26.039(b) and 30 TAC §327.3(b), by failing to notify the TCEQ as soon as possible but no later than 24 hours after the discovery of a spill or discharge; TWC, §26.266(a) and 30 TAC §327.5(a), by failing to immediately abate and contain a discharge or spill; and 30 TAC §327.5(c), by failing to submit written information, describing the details of the discharge or spill and supporting the adequacy of the response action, to the appropriate TCEQ Regional Manager within 30 working days of the discovery of the reportable discharge or spill; PENALTY: $3,937; STAFF ATTORNEY: Audrey Liter, Litigation Division, MC 175, (512) 239-0684; REGIONAL OFFICE: San Angelo Regional Office, 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

TRD-201900002
Charmaine Backens
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 2, 2019

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Texas Ethics Commission

List of Late Filers

Below is a list from the Texas Ethics Commission naming the filers who failed to pay the penalty fine for failure to file the report, or filing a late report, in reference to the specified filing deadline. If you have any questions, you may contact Sue Edwards at (512) 463-5800.

Deadline: 8-Day Pre-Election Report due October 29, 2018, for Candidates and Officeholders

Kevin P. Ludlow, 1235 Broadmoor Dr., Austin, Texas 78723

Jesse F. McClure, P.O. Box 53901, Houston, Texas 77052

Thresa A. Meza, P.O. Box 155076, Irving, Texas 75015

Francisco G. Nila, 19332 James Manor St., Manor, Texas 78653

Matthew S. Pina, 10907 Lisbon, San Antonio, Texas 78213

Lee W. Sharp, 7802 Redding Rd., Houston, Texas 77036

Demetrius Walker, 5719 Vinemont Ln., Houston, Texas 77084

Deadline: Semiannual Report due July 16, 2018, for Committees

Johnny Arrendondo, Republican Club of Bexar County, P.O. Box 691183, San Antonio, Texas 78269

Robert L. Bruce, Texas Association of Conservative Teachers, 1640 Briarcrest Dr., Ste. 122, Bryan, Texas 77802

Danielle Burrell, Houston Area COGIC PAC, 7863 Split Oak, Houston, Texas 77040

Amber Burton, Vote Local, 18482 Kuykendahl Rd., #199, Spring, Texas 77379

Stuart Campbell, Harris County Deputies Org. 1314 Texas St. #2000, Houston, Texas 77002

Brian D. Crumby, Conservative Coalition of Montgomery County, 14918 Timbershade Crossing, Magnolia, Texas 77355

Stephen V. David, Filipino American Caucus for Empowerment - PAC, c/o Nelvin Adriatico, 4655 Sweetwater Blvd., #100, Sugar Land, Texas 77479

Wilson Davis, Texans For Stem Cells, 4719 S. Congress Ave., Austin, Texas 78745

Leslie Ficke, Highland Park Community League, 25 Highland Park Village #100-533, Dallas, Texas 75205

Mary Kathryn Hailey, Democratic Women of Galveston County, 410 Clearview Ave., Friendswood, Texas 77546

Syed Fayyaz Hassan, DFW Dems, 601 Engleside Dr., Arlington, Texas 76018

Tiffany Frinzi, Mobile Health Alliance PAC, 3736 Bee Cave Rd., Ste. 1-164, West Lake Hills, Texas 78746

Linda M. Jackson, Alamo City Democrats PAC, 9406 Charter Pt., San Antonio, Texas 78250

Eric Knustrom, The Texas PAC, 1122 Colorado St., Ste. 102, Austin, Texas 78701

Ruth M. Leal, Mission Democrats of Bexar County, 6246 Deer Valley Dr., San Antonio, Texas 78242

Santiago Manrrique, Opportunities for Brownsville PAC, P.O. Box 1894, Los Fresnos, Texas 78566

Darwin McKee, Central Texas PAC Centre Development, P.O. Box 14105, Austin, Texas 78761

Rick Miller, Texas Veterans Caucus, P.O. Box 2910, Austin, Texas 78768-2910

William E. Miller, Harris County Council of Organizations PAC, 9668 Westheimer 200-134, Houston, Texas 77063

Gary L. Moody, Neighbors For McLendon - Chisholm, P.O. Box 1954, Rockwall, Texas 75089

Lucius O'Dell, Texans for Conservative Government PAC, 2830 S. Hullen St., #229, Fort Worth, Texas 76109

Anne Pickle, Jasper County Republican Women, P.O. Box 894, Jasper, Texas 75957

Ken Reeves, Waco Police Association PAC, 408 S. 7th, Valley Mills, Texas 76689

Alan Sandersen, Fort Bend Business PAC, 130 Industrial Blvd., Ste. 130, Sugar Land, Texas 77478

John K. Sparks, Holly Lake - Hawkins Republican Club, 124 Bobwhite Ln., Holly Lake Ranch, Texas 75765

Sherri T. Statler, Abilene PAC, P.O. Box 2482, Abilene, Texas 79604

Terresa Stewart, Andrews County Republican Women, #1 Louis Cir., Andrews, Texas 79714

Jesus Urenda, Eastside Democrats, 10345 Luella, El Paso, Texas 79925

TRD-201805547
Seana Willing
Executive Director
Texas Ethics Commission
Filed: December 20, 2018

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Office of the Governor

Notice of Available Funding Opportunities

Office of the Governor, Public Safety Office (PSO)

The Homeland Security Grants Division (HSGD), located in the PSO, is announcing the following funding opportunities for State Fiscal Year 2020. Details for each opportunity, including the open and close date for the solicitations, can be found on the eGrants Calendar (https://eGrants.gov.texas.gov/fundopp.aspx).

Nonprofit Security Program (NSGP)--The purpose of this solicitation is to integrate the preparedness activities of nonprofit organizations that are at high risk of a terrorist attack with broader state and local preparedness efforts. The NSGP supports projects for physical security enhancements and other security activities to nonprofit organizations that are at high risk of a terrorist attack based on the nonprofit organization's ideology, beliefs or mission. The NSGP also serves to promote emergency preparedness coordination and collaboration activities between public and private entities.

TRD-201900005
Aimee Snoddy
PSO Executive Director
Office of the Governor
Filed: January 2, 2019

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Texas Groundwater Protection Committee

Adoption of Texas Groundwater Protection Strategy Update

Pursuant to Texas Water Code, §26.405(2), the Texas Groundwater Protection Committee (TGPC or committee) has completed the process of updating its *Texas Groundwater Protection Strategy (Strategy)* and adopted the updates to the *Strategy* at the quarterly public meeting on October 17, 2018.

The updates to the *Strategy* are adopted without change to the proposal that was noticed in the July 13, 2018, issue of the *Texas Register* (43 TexReg 4790).

Background and Summary of the Factual Basis for the Adopted *Strategy*

Created by the 71st Texas Legislature in 1989, the TGPC strives to identify areas where new or existing Texas groundwater programs could be enhanced, as well as improve coordination among the state agencies and statewide organizations involved in groundwater-related activities. The TGPC also provides a means for the public to interact with groundwater experts.

One of the TGPC's legislative mandates is to develop and update a comprehensive groundwater protection strategy for the state that provides guidelines for groundwater conservation and the prevention of groundwater contamination. The comprehensive strategy for protecting groundwater in Texas includes both the TGPC member's internal

programs and the TGPC's internal processes outlined in the adopted *Strategy* update.

The adopted updates streamline the *Strategy* for better integration into the TGPC's vision for all of the committee's mandated reports. By streamlining the documents, the TGPC has sought to reduce redundancy, and increase the inter-dependency between the mandated products of the legislation that created the committee. The adopted updates also represent an initial move toward a dynamic document that is capable of being updated rapidly to respond not only to the rapid advances in groundwater technology and contaminant detection and forecasting, but also to issues that are not anticipated at this time. The TGPC believes that a dynamic strategy, which facilitates addressing not only the "known" groundwater issues, but emerging groundwater issues, is critical to maintaining the protection of the resource.

The principles and the mechanisms that characterize groundwater for protection and conservation identified in the previous *Strategy,* (AS-188 (February 2003)), are not in any way invalid, amended, modified, or "repealed," and remain in effect. Similarly, no existing groundwater protection measure acquired, adopted, or incurred; nor any rule or order adopted; nor any proceeding instituted by the program areas of any member agency that were pursuant to AS-188 (February 2003), are affected by the adoption of the updated *Strategy.*

The updated *Strategy* addresses a new approach to the contents of the remaining chapters in AS-188 (February 2003), and, as mentioned previously, is the initial framework for a dynamic *Strategy* moving forward.

Public Comment

The comment period closed on August 13, 2018. At the TGPC's quarterly public meeting on October 17, 2018, the responses to the public comments regarding the proposed *Strategy* updates were presented and approved. The record of the meeting, including the committee's responses to the public comments, can be found at *https://tgpc.texas.gov/TGPCminutes17Oct2018.pdf.*

The updated *Strategy* can be found at *https://www.tceq.texas.gov/assets/public/comm_exec/pubs/as/188.pdf.*

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

TRD-201805579
Cary Betz
Chair
Texas Groundwater Protection Committee
Filed: December 28, 2018

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Texas Lottery Commission

Scratch Ticket Game Number 2052 "$50,000 Bonus Cashword"

A. The name of Scratch Ticket Game No. 2052 is "$50,000 BONUS CASHWORD". The play style is "crossword".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2052 shall be $3.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2052.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y and Z.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. Crossword and Bingo style games do not typically have Play Symbol Captions. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2052 - 1.2D

PLAY SYMBOL	CAPTION
A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	
U	
V	
W	
X	
Y	
Z	

E. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Scratch Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Pack-Scratch Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (2052), a seven (7) digit Pack number, and a three (3) digit Scratch Ticket number. Scratch Ticket numbers start with 001 and end with 125 within each Pack. The format will be: 2052-0000001-001.

H. Pack - A Pack of "$50,000 BONUS CASHWORD" Scratch Ticket Game contains 125 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be 2 fanfold configurations for this game. Configuration A will show the front of ticket 001 and the back of ticket 125. Configuration B will show the back of ticket 001 and the front of ticket 125.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable

rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket, or Ticket - Texas Lottery "$50,000 BONUS CASHWORD" Scratch Ticket Game No. 2052.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general Scratch Ticket validation requirements set forth in Texas Lottery Rule 401.302, Scratch Ticket Game Rules, these Game Procedures, and the requirements set out on the back of each Scratch Ticket. A prize winner in the "$50,000 BONUS CASHWORD" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose 101 (one hundred and one) Play Symbols. The player scratches all of the YOUR 20 LETTERS Play Symbols and the two BONUS LETTERS. Then the player scratches all the letters found in the $50,000 BONUS CASHWORD puzzle that exactly match the YOUR 20 LETTERS and BONUS LETTERS. If the player has scratched at least 3 complete WORDS, the player wins the prize found in the PRIZE LEGEND. Only one prize paid per ticket. Only letters within the $50,000 BONUS CASHWORD puzzle that are matched with the YOUR 20 LETTERS and BONUS LETTERS can be used to form a complete WORD. Every letter within an unbroken horizontal (left to right) or vertical (top to bottom) sequence must be matched with the YOUR 20 LETTERS and BONUS LETTERS to be considered a complete WORD. Words revealed in a diagonal sequence are not considered valid WORDS. Words within WORDS are not eligible for a prize. Words that are spelled from right to left or bottom to top are not eligible for a prize. A complete WORD must contain at least three letters. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly 101 (one hundred and one) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption; Crossword and Bingo games do not typically have Play Symbol Captions;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Scratch Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Scratch Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly 101 (one hundred and one) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Scratch Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 101 (one hundred and one) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 101 (one hundred and one) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Scratch Ticket Number must be printed in the Pack-Scratch Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of Play Symbols.

B. GENERAL: There is no correlation between any exposed data on a Ticket and its status as a winner or non-winner.

C. CROSSWORD GAMES: The grid on each Ticket will contain exactly the same number of letters.

D. CROSSWORD GAMES: The grid on each Ticket will contain exactly the same number of words.

E. CROSSWORD GAMES: No matching words on a Ticket.

F. CROSSWORD GAMES: All words used will be from the TEXAS APPROVED WORD LIST CASHWORD/CROSSWORD v.1.2, dated December 4, 2017.

G. CROSSWORD GAMES: All words will contain a minimum of 3 letters.

H. CROSSWORD GAMES: All words will contain a maximum of 9 letters.

I. CROSSWORD GAMES: There will be a minimum of three (3) vowels in the YOUR 20 LETTERS and the BONUS LETTERS play areas. Vowels are considered to be A, E, I, O, U.

J. CROSSWORD GAMES: No consonant will appear more than nine (9) times, and no vowel will appear more than fourteen (14) times in the grid.

K. CROSSWORD GAMES: No matching Play Symbols in the YOUR 20 LETTERS play area.

L. CROSSWORD GAMES: At least fifteen (15) of the letters in the YOUR 20 LETTERS and BONUS LETTERS play areas will open at least one (1) letter in the grid.

M. CROSSWORD GAMES: The presence or absence of any letter or combination of letters in the YOUR 20 LETTERS and the BONUS LETTERS play areas will not be indicative of a winning or Non-Winning Ticket.

N. CROSSWORD GAMES: Words from the TEXAS REJECTED WORD LIST v.2.3, dated December 4, 2017, will not appear horizontally in the YOUR 20 LETTERS play area when read left to right or right to left.

O. CROSSWORD GAMES: On Non-Winning Tickets, there will be two (2) completed words in the grid.

P. CROSSWORD GAMES: There will be a random distribution of all Play Symbols on the Ticket, unless restricted by other parameters, play action or prize structure.

Q. CROSSWORD GAMES: There will be no more than twelve (12) complete words in the grid.

R. A Ticket can only win one (1) time.

S. CROSSWORD GAMES: The two (2) BONUS LETTERS Play Symbols will not match any of the YOUR 20 LETTERS Play Symbols on a Ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "$50,000 BONUS CASHWORD" Scratch Ticket Game prize of $3.00, $5.00, $10.00, $15.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $100 or $500 Scratch Ticket Game Prize. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$50,000 BONUS CASHWORD" Scratch Ticket Game prize of $5,000 or $50,000, the claimant must sign the winning Scratch Ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$50,000 BONUS CASHWORD" Scratch Ticket Game prize, the claimant must sign the winning Scratch Ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. A sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the Scratch Ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize under $600 from the "$50,000 BONUS CASHWORD" Scratch Ticket Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$50,000 BONUS CASHWORD" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket Game prizes must be claimed within 180 days following the end of the Scratch Ticket

Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 35,760,000 Scratch Tickets in Scratch Ticket Game No. 2052. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2052 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$3	3,933,600	9.09
$5	2,002,560	17.86
$10	1,716,480	20.83
$15	500,640	71.43
$20	429,120	83.33
$50	143,040	250.00
$100	58,110	615.38
$500	2,980	12,000.00
$5,000	89	401,797.75
$50,000	18	1,986,666.67

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.07. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2052 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket Game closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2052, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-201805590
Bob Biard
General Counsel
Texas Lottery Commission
Filed: December 31, 2018

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Public Utility Commission of Texas

Public Notice of Workshop

Staff of the Public Utility Commission of Texas (commission staff) will hold a workshop seeking input from Retail Electric Providers (REPs) and interested parties regarding the Power to Choose website and the methodology of the complaint scorecard. The workshop will be held at 9:00 a.m. on Wednesday January 23, 2019, in the Commissioners' Hearing Room, located on the 7th floor of the William B. Travis Building, 1701 N. Congress Avenue, Austin, Texas, 78701. Project No. 49052 - PROJECT TO EVALUATE THE POWER TO CHOOSE WEBSITE AND METHODOLOGY OF THE SCORECARD, has been established for this proceeding.

Parties that wish to may file on or before Wednesday, January 9, 2019, a proposed draft agenda, proposed questions for discussion, or general comments on the topic. The parties' proposals will be discussed at the January 23, 2019, workshop.

Questions concerning the workshop or this notice should be referred to Chris Burch, Customer Protection Division, at (512) 936-7145 or Chris.Burch@puc.texas.gov. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission through Relay Texas by dialing 7-1-1.

TRD-201805591
Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 31, 2018

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South Plains Association of Governments

Public Notice--Notice of Solicitation for Nominations for Persons to Serve on the Llano Estacado Regional Water Planning Group - Region O

Municipalities (small) of populations less than 10,000

Regional Water Planning in the State of Texas is the local process which guides conservation and water projects. The Regional Water Plans, upon approval by the Texas Water Development Board (TWDB), are used to help develop the State Water Plan, which guides state funding of water projects.

The South Plains Association of Governments (SPAG), is the designated political subdivision (Administrative Agency) approved by the Llano Estacado Regional Water Planning Group (LERWPG) and encompasses the following counties: Bailey, Briscoe, Castro, Cochran, Crosby, Dawson, Deaf Smith, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Motley, Parmer, Swisher, Terry, and Yoakum.

Notice is hereby given that the Llano Estacado Regional Water Planning Group (LERWPG) is soliciting nominations for a person to serve as a voting member on the Llano Estacado RWPG representing Municipalities (small) of populations less than 10,000. The selected representative will serve the remainder of a five-year term ending December 31, 2019, and will be eligible to re-apply for the following five-year term.

Municipalities (small--population less than 10,000), are defined as governments of cities, created or organized under the general, home-rule, or special laws of the state.

To qualify for voting membership on the Llano Estacado Regional Water Planning Group (LERWPG) nominees must represent the interest group category for which a member is sought within the Region O planning area, be willing to participate in the regional water planning process, and abide by the Bylaws of Llano Estacado RWPG.

Deadline for submission of nominations is Friday, January 18, 2019. Nominations may be mailed or emailed. A nomination packet for candidates should include a cover letter from the nominee explaining how the nominee is qualified to serve on the LERWPG, a resume, and a minimum of two (and a maximum of six) letters of support. At least one support letter should be from a member of the Llano Estacado RWPG.

Appointment of a voting member to represent the above-mentioned interest may be considered by the Llano Estacado RWPG at the February 20, 2019, meeting or at a future meeting as determined by the RWPG.

For more information, or to submit nominations, please contact the administrative agency listed below:

South Plains Association of Governments

Attention: Kelly Davila

Post Office Box 3730

Lubbock, Texas 79452

(806) 762-8721

kdavila@spag.org

TRD-201805581
Belinda Solis
Regional Services Program Assistant
South Plains Association of Governments
Filed: December 28, 2018

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Solicitation of Nominations for Electric Generating Utilities

Public Notice--Notice of solicitation for nominations for persons to serve on the Llano Estacado Regional Water Planning Group - Region O

Regional Water Planning in the State of Texas is the local process which guides conservation and water projects. The Regional Water Plans, upon approval by the Texas Water Development Board (TWDB), are used to help develop the State Water Plan, which guides state funding of water projects.

The South Plains Association of Governments (SPAG), is the designated political subdivision (Administrative Agency) approved by the Llano Estacado Regional Water Planning Group (LERWPG) and encompasses the following counties: Bailey, Briscoe, Castro, Cochran, Crosby, Dawson, Deaf Smith, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Motley, Parmer, Swisher, Terry, and Yoakum.

Notice is hereby given that the Llano Estacado Regional Water Planning Group (LERWPG) is soliciting nominations for a person to serve as a voting member on the Llano Estacado RWPG representing Electric generating utilities. The selected representative will serve the remainder of a five-year term ending December 31, 2019, and will be eligible to re-apply for the following five-year term.

Electric generating utilities, defined as any persons, corporations, cooperative corporations, or any combination thereof, meeting each of the following three criteria: own or operate for compensation equipment or facilities which produce or generate electricity; produce or generate electricity for either wholesale or retail sale to others; and are neither a municipal corporation not a river authority.

To qualify for voting membership on the Llano Estacado Regional Water Planning Group (LERWPG) nominees must represent the interest group category for which a member is sought within the Region O

planning area, be willing to participate in the regional water planning process, and abide by the Bylaws of Llano Estacado RWPG.

Deadline for submission of nominations is Friday, January 18, 2019. Nominations may be mailed or emailed. A nomination packet for candidates should include a cover letter from the nominee explaining how the nominee is qualified to serve on the LERWPG, a resume, and a minimum of two (and a maximum of six) letters of support. At least one support letter should be from a member of the Llano Estacado RWPG.

Appointment of a voting member to represent the above mentioned interest may be considered by the Llano Estacado RWPG at the February 20, 2019, meeting or at a future meeting as determined by the RWPG.

For more information, or to submit nominations, please contact the administrative agency listed below:

South Plains Association of Governments Attention: Kelly Davila

Post Office Box 3730 Lubbock, Texas 79452

(806) 762-8721

kdavila@spag.org

TRD-201805580
Belinda Solis
Regional Services Program Assistant
South Plains Association of Governments
Filed: December 28, 2018

♦ ♦ ♦

Texas Department of Transportation

Aviation Division - Request for Qualifications (RFQ) for Professional Engineering Services

The City of Giddings and Lee County, through their agent, the Texas Department of Transportation (TxDOT), intend to engage a professional engineering firm for services pursuant to Chapter 2254, Subchapter A, of the Government Code. TxDOT Aviation Division will solicit and receive qualification statements for the current aviation project as described below.

Current Project: City of Giddings and Lee County; TxDOT CSJ No.: 1814GIDNG.

The TxDOT Project Manager is Paul Slusser.

Scope: Provide engineering and design services, including construction administration, to:

1. Rehabilitate and mark runway.

2. Rehabilitate and mark apron, stub taxiway, and turnarounds runway.

3. Replace medium intensity runway lights, Precision Approach Path Indicators, windcone, rotating beacon and electrical vault.

The Agent, in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (78 Stat. 252, 42 U.S.C. §§2000d to 2000d-4) and the Regulations, hereby notifies all respondents that it will affirmatively ensure that for any contract entered into pursuant to this advertisement, disadvantaged business enterprises will be afforded full and fair opportunity to submit in response to this solicitation and will not be discriminated against on the grounds of race, color, or national origin in consideration for an award.

The proposed contract is subject to 49 CFR Part 26 concerning the participation of Disadvantaged Business Enterprises (DBE).

The DBE goal for the design phase of the current project is 10%. The goal will be re-set for the construction phase.

Utilizing multiple engineering/design and construction grants over the course of the next five years, future scope of work items at the Giddings-Lee County Airport may include the following: construct/expand north apron; rehabilitate hangar taxi lanes; relocate/reconstruct airport entrance road; construct north partial parallel taxiway to Runway 17; remove/relocate old T-hangars; and relocate/replace shade hangars.

The City of Giddings and Lee County reserve the right to determine which of the services listed above may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services listed above.

To assist in your qualification statement preparation, the criteria, project diagram, and most recent Airport Layout Plan are available online by selecting "Giddings-Lee County Airport" at: *http://www.dot.state.tx.us/avn/avninfo/notice/consult/index.htm.*

The qualification statement should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects.

AVN-550 Preparation Instructions:

Interested firms shall utilize the latest version of Form AVN-550, titled "Qualifications for Aviation Architectural/Engineering Services." The form may be requested from TxDOT, Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number (800) 68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT website at: *http://www.txdot.gov/inside-txdot/division/aviation/projects.html.*

The form may not be altered in any way. Firms must carefully follow the instructions provided on each page of the form. Qualifications shall not exceed the number of pages in the AVN-550 template. The AVN-550 consists of eight pages of data plus one optional illustration page. A prime provider may only submit one AVN-550. If a prime provider submits more than one AVN-550, or submits a cover page with the AVN-550, that provider will be disqualified. Responses to this solicitation WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

The completed Form AVN-550 must be received in the TxDOT Aviation eGrants system no later than February 05, 2019, 11:59 p.m. (CDST). Electronic facsimiles or forms sent by email or regular/overnight mail will not be accepted.

Firms that wish to submit a response to this solicitation must be a user in the TxDOT Aviation eGrants system no later than one business day before the solicitation due date. To request access to eGrants, please complete the Contact Us web form located at: *http://txdot.gov/government/funding/egrants-2016/aviation.html.*

An instructional video on how to respond to a solicitation in eGrants is available at: *http://txdot.gov/government/funding/egrants-2016/aviation.html.*

Step by step instructions on how to respond to a solicitation in eGrants will also be posted in the RFQ packet at: *http://www.dot.state.tx.us/avn/avninfo/notice/consult/index.htm.*

The consultant selection committee will be composed of local government representatives. The final selection by the committee will generally be made following the completion of review of AVN-550s. The committee will review all AVN-550s and rate and rank each. The

Evaluation Criteria for Engineering Qualifications can be found under Information for Consultants at: *http://www.txdot.gov/inside-txdot/division/aviation/projects.html.*

All firms will be notified and the top rated firm will be contacted to begin fee negotiations for the design and bidding phases. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at (800) 68-PILOT (74568). For procedural questions, please contact Anna Ramirez, Grant Manager. For technical questions, please contact Paul Slusser, Project Manager.

For questions regarding responding to this solicitation in eGrants, please contact the TxDOT Aviation help desk at (800) 687-4568 or *avn-egrantshelp@txdot.gov.*

TRD-201805592
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 31, 2018

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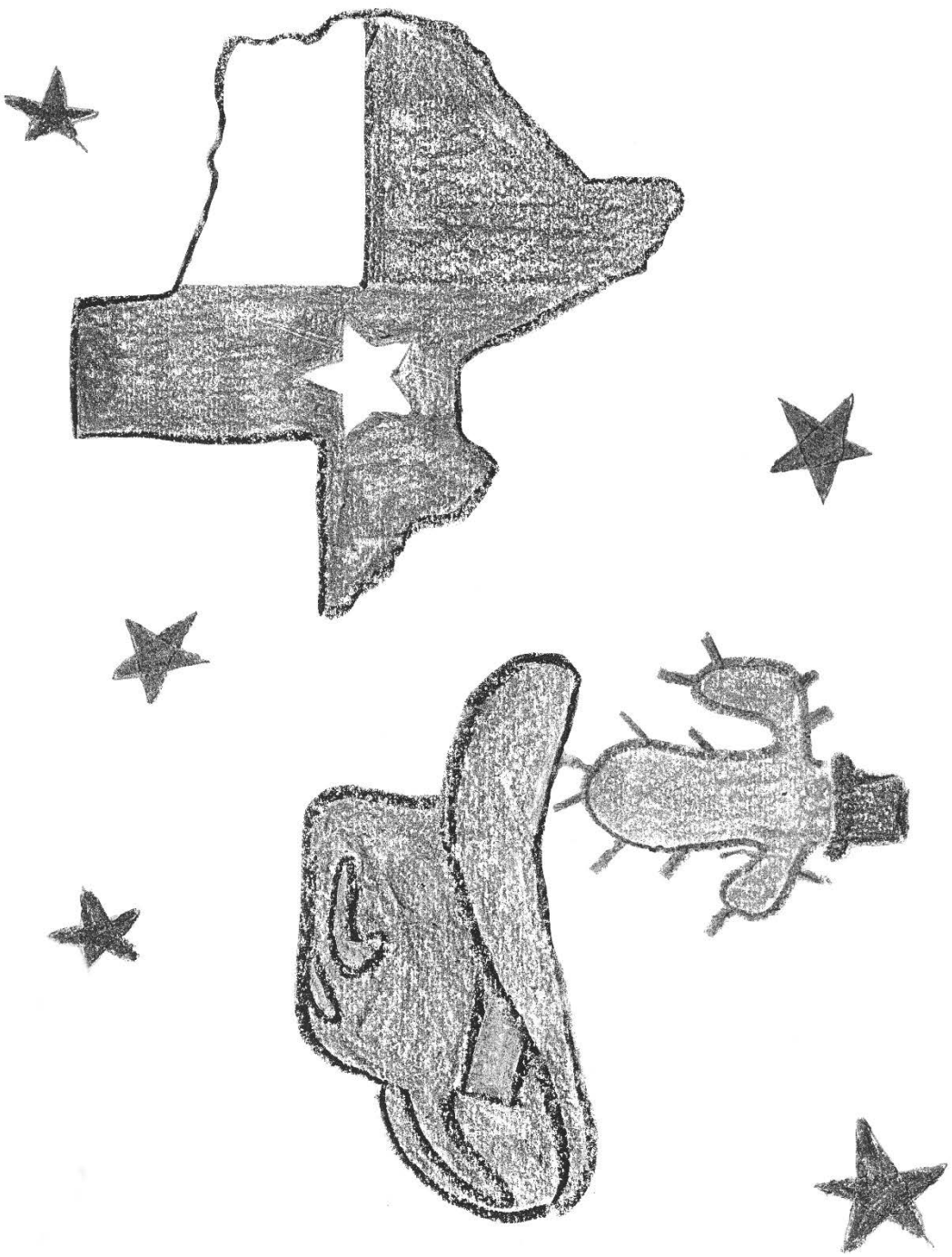

How to Use the Texas Register

Information Available: The sections of the *Texas Register* represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules - sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Review of Agency Rules - notices of state agency rules review.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules - notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the *Texas Register* is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 43 (2018) is cited as follows: 43 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "43 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 43 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the *Texas Register* office, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using *Texas Register* indexes, the *Texas Administrative Code* section numbers, or TRD number.

Both the *Texas Register* and the *Texas Administrative Code* are available online at: http://www.sos.state.tx.us. The *Texas Register* is available in an .html version as well as a .pdf version through the internet. For website information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The *Texas Administrative Code (TAC*) is the compilation of all final state agency rules published in the *Texas Register*. Following its effective date, a rule is entered into the *Texas Administrative Code*. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the *TAC*.

The *TAC* volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete *TAC* is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The Titles of the *TAC*, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
26. Health and Human Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the *Texas Administrative Code*; *TAC* stands for the *Texas Administrative Code*; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to Update: To find out if a rule has changed since the publication of the current supplement to the *Texas Administrative Code*, please look at the *Index of Rules*.

The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the *Texas Register*.

If a rule has changed during the time period covered by the table, the rule's *TAC* number will be printed with the *Texas Register* page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
1 TAC §91.1…….....950 *(P)*

SALES AND CUSTOMER SUPPORT

Sales - To purchase subscriptions or back issues, you may contact LexisNexis Sales at 1-800-223-1940 from 7am to 7pm, Central Time, Monday through Friday. Subscription cost is $438 annually for first-class mail delivery and $297 annually for second-class mail delivery.

Customer Support - For questions concerning your subscription or account information, you may contact LexisNexis Matthew Bender Customer Support from 7am to 7pm, Central Time, Monday through Friday.

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