TEXAS REGISTER

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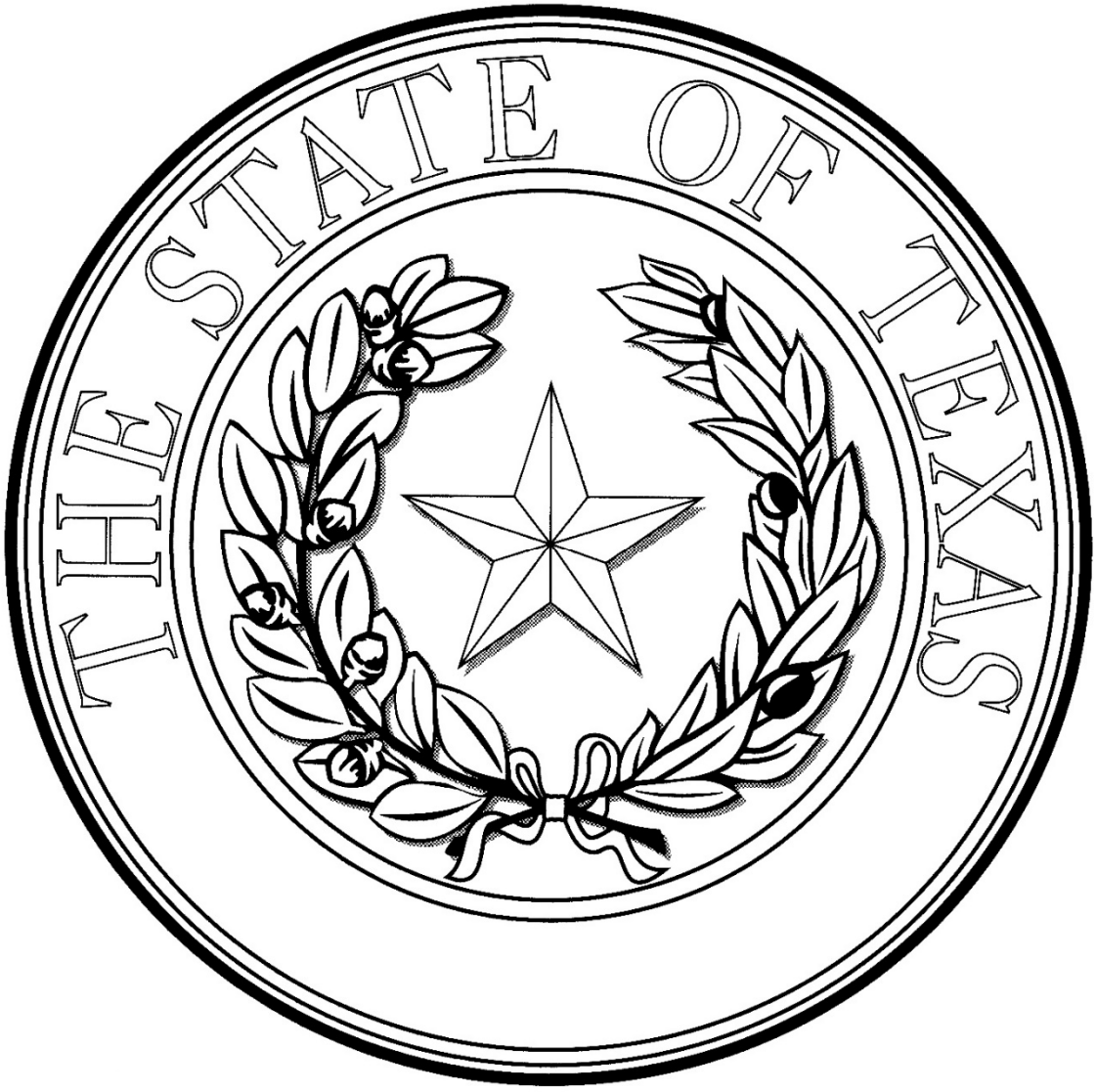

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THE GOVERNOR

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

Appointments

Appointments for March 28, 2023

Appointed to the Governing Board of the Texas Civil Commitment Office for a term to expire February 1, 2029, Roberto "Robert" Dominguez of Elsa, Texas (Mr. Dominguez is being reappointed).

Appointed to the Governing Board of the Texas Civil Commitment Office for a term to expire February 1, 2023, Elizabeth C. "Christy" Jack of Fort Worth, Texas (Ms. Jack is being reappointed).

Appointed to the Texas State University System Board of Regents for a term to expire February 1, 2029, Earl C. "Duke" Austin, Jr. of Houston, Texas (Mr. Austin is being reappointed).

Appointed to the Texas State University System Board of Regents for a term to expire February 1, 2029, Russell D. Gordy of Houston, Texas (replacing Veronica R. "Nicki" Harle of Baird, whose term expired).

Appointed to the Texas State University System Board of Regents for a term to expire February 1, 2029, Thomas E. "Tom" Long of Frisco, Texas (replacing Garry D. Crain of The Hills, whose term expired).

Appointments for March 29, 2023

Appointed to the Dental Review Committee for a term to expire February 1, 2029, Chris L. Cramer, D.D.S. of Coppell, Texas (replacing Jesse Teng, D.D.S of El Paso whose term expired).

Appointed to the Dental Review Committee for a term to expire February 1, 2029, Nancy A. Evans, D.D.S of Denton, Texas (Dr. Evans is being reappointed).

Appointed to the Dental Review Committee for a term to expire February 1, 2029, Amanda M. Richardson of Tyler, Texas (Ms. Richardson is being reappointed).

Appointed to the State Board for Educator Certification as a non-voting member for a term to expire February 1, 2029, Alma D. Rodriguez, Ed.D. of Rancho Viejo, Texas (Dr. Rodriguez is being reappointed).

Appointments for March 30, 2023

Appointed to the Commission on Jail Standards for a term to expire January 31, 2029, Duane Lock of Southlake, Texas (Mr. Lock is being reappointed).

Appointed to the Commission on Jail Standards for a term to expire January 31, 2029, Andrew B. "Ben" Perry of Waco, Texas (Mr. Perry is being reappointed).

Appointed to the Commission on Jail Standards for a term to expire January 31, 2029, Esmaeil Porsa, M.D. of Houston, Texas (Mr. Porsa is being reappointed).

Appointed to the Texas Board of Professional Geoscientists for a term to expire February 1, 2029, Mark N. Varhaug of Dallas, Texas (Mr. Varhaug is being reappointed).

Designating William "David" Prescott, II of Amarillo as presiding officer of the Texas Board of Professional Geoscientists for a term to expire at the pleasure of the Governor. Mr. Prescott is replacing Becky L. Johnson of Fort Worth as presiding officer.

Appointments for April 4, 2023

Appointed to the Texas Real Estate Commission for a term to expire January 31, 2029, Stuart A. Bernstein of Austin, Texas (replacing Michael "Mike" Williams of Colleyville, whose term expired).

Appointed to the Texas Real Estate Commission for a term to expire January 31, 2029, Chance A. Brown of Cypress, Texas (replacing De-Lora Wilkinson of Cypress, whose term expired).

Appointed to the Texas Real Estate Commission for a term to expire January 31, 2029, Renee Williams Harvey Lowe of Clarksville, Texas (replacing Jan Fite Miller of Kemp, whose term expired).

Appointed to the Texas Appraiser Licensing and Certification Board for a term to expire January 31, 2029, Rolando F. Castro of Cypress, Texas (Mr. Castro is being reappointed).

Appointed to the Texas Appraiser Licensing and Certification Board for a term to expire January 31, 2029, John H. Eichelberger, III of West University Place, Texas (replacing Clayton P. Black of Stanton, whose term expired).

Greg Abbott, Governor

TRD-202301280

♦ ♦ ♦

Proclamation 41-3965

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, I, GREG ABBOTT, Governor of the State of Texas, issued a disaster proclamation on July 8, 2022, as amended and renewed in a number of subsequent proclamations, certifying that exceptional drought conditions posed a threat of imminent disaster in several counties; and

WHEREAS, the Texas Division of Emergency Management has confirmed that those same drought conditions continue to exist in these and other counties in Texas;

NOW, THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby amend and renew the aforementioned proclamation and declare a disaster in Andrews, Aransas, Atascosa, Austin, Bandera, Brooks, Baylor, Bee, Bell, Bexar, Blanco, Borden, Bosque, Brown, Burnet, Caldwell, Callahan, Cameron, Castro, Childress, Colorado, Collingsworth, Comal, Comanche, Coryell, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Dimmit, Duval, Eastland, Edwards, Erath, Falls, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Gonzales, Grimes, Guadalupe, Hale, Hamilton, Hansford, Hardeman, Hartley, Hays, Henderson, Hidalgo, Howard, Hutchinson, Jim Hogg, Jim Wells, Jones, Kendall, Kenedy, Kent, Kerr, Kimble, King, Kinney, Kleberg, La Salle, Lipscomb, Llano, Lubbock, Lynn, Martin, Mason, Maverick, McLennan, Medina, Menard, Mills, Mitchell, Montgomery, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Potter, Randall, Real,

Roberts, Scurry, Shackelford, Sherman, Starr, Stonewall, Swisher, Taylor, Terry, Travis, Uvalde, Webb, Wharton, Yoakum, Zapata, and Zavala Counties.

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

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

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

IN TESTIMONY WHEREOF, I have hereunto signed my name and have officially caused the Seal of State to be affixed at my office in the City of Austin, Texas, this the 31st day of March, 2023.

Greg Abbott, Governor

TRD-202301255

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THE ATTORNEY GENERAL

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

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

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

Opinions

Opinion No. KP-0440

The Honorable Harold V. Dutton, Jr.

Chair, House Committee on Juvenile Justice & Family Issues

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Questions related to public-private partnerships for state-funded prekindergarten offered by Texas school districts under Education Code section 29.153 (RQ-0480-KP)

S U M M A R Y

Section 29.153 of the Education Code provides for free prekindergarten for certain eligible children. To the extent a school district seeks an exemption from the application of its provisions pursuant to subsection 29.153(d), the provisions of subsection 29.153(d-1) concerning the solicitation of public-private partnerships are mandatory to receive the exemption. Subsection 29.153(g), which likewise concerns the solicitation of public-private partnerships, is mandatory for any school district that needs to construct, repurpose, or lease a classroom facility or issue bonds for such construction or repurposing in order to provide prekindergarten classes to eligible children who are at least four years old.

The contract eligibility provisions of subsection 29.171(b) should not be applied as a condition of submitting a proposal under subsection 29.153(g).

A renewal of an existing exemption obtained pursuant to subsection 29.153(d-1) does not necessarily require a new round of partnership proposal solicitations.

Compliance with subsections 29.153(d-1) and (g) for school districts seeking an exemption pursuant to subsection 29.153(d) is mandatory regardless of the underlying level of interest in participating in public-private partnerships.

To the extent any Texas Education Agency guidelines have general applicability and implement, interpret, or prescribe law or policy, or describe the procedure or practice requirements of the agency, a court would have a basis under the Administrative Procedure Act for concluding that they should be promulgated through formal rulemaking.

A court would likely conclude that neither the Governor's COVID-19 Disaster Declaration nor any related Executive Order authorize the suspension of subsections 29.153(d-1) or (g).

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

TRD-202301276
Austin Kinghorn
General Counsel
Office of the Attorney General
Filed: April 4, 2023

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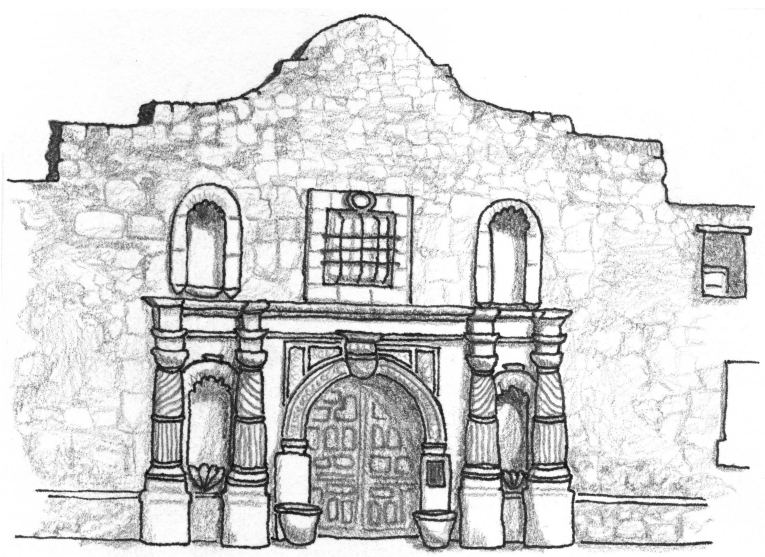

EMERGENCY RULES

Emergency Rules include new rules, amendments to existing rules, and the repeals of existing rules. A state agency may adopt an emergency rule without prior notice or hearing if the agency finds that an imminent peril to the public health, safety, or welfare, or a requirement of state or federal law, requires adoption of a rule on fewer than 30 days' notice. An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days (Government Code, §2001.034).

TITLE 1. ADMINISTRATION

PART 4. OFFICE OF THE SECRETARY OF STATE

CHAPTER 94. ELECTRIC COOPERATIVE SECURITIZED PROPERTY NOTICE FILINGS

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §§94.1 - 94.7

The Office of the Secretary of State is renewing the effectiveness of emergency new §§94.1 - 94.7 for a 60-day period. The text of the emergency rules was originally published in the December 16, 2022, issue of the *Texas Register* (47 TexReg 8165).

Filed with the Office of the Secretary of State on March 30, 2023.

TRD-202301227
Adam Bitter
General Counsel
Office of the Secretary of State
Original effective date: December 2, 2022
Expiration date: May 30, 2023
For further information, please call: (512) 463-5770

♦ ♦ ♦

SUBCHAPTER B. DUTIES OF FILING OFFICER

1 TAC §§94.20 - 94.22

The Office of the Secretary of State is renewing the effectiveness of emergency new §§94.20 - 94.22 for a 60-day period. The text of the emergency rules was originally published in the December 16, 2022, issue of the *Texas Register* (47 TexReg 8165).

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SUBCHAPTER C. STANDARDS OF REVIEW AND INDEXING

1 TAC §§94.40 - 94.44

The Office of the Secretary of State is renewing the effectiveness of emergency new §§94.40 - 94.44 for a 60-day period. The text of the emergency rules was originally published in the December 16, 2022, issue of the *Texas Register* (47 TexReg 8165).

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General Counsel
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For further information, please call: (512) 463-5770

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SUBCHAPTER D. FILINGS

1 TAC §§94.60 - 94.66

The Office of the Secretary of State is renewing the effectiveness of emergency new §§94.60 - 94.66 for a 60-day period. The text of the emergency rules was originally published in the December 16, 2022, issue of the *Texas Register* (47 TexReg 8165).

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Adam Bitter
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Office of the Secretary of State
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For further information, please call: (512) 463-5770

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SUBCHAPTER E. SEARCH AND INFORMATION REQUESTS

1 TAC §§94.80 - 94.82

The Office of the Secretary of State is renewing the effectiveness of emergency new §§94.80 - 94.82 for a 60-day period. The text of the emergency rules was originally published in the December 16, 2022, issue of the *Texas Register* (47 TexReg 8165).

Filed with the Office of the Secretary of State on March 30, 2023.

TRD-202301231

Adam Bitter
General Counsel
Office of the Secretary of State
Original effective date: December 2, 2022
Expiration date: May 30, 2023
For further information, please call: (512) 463-5770

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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 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology, §355.8066, concerning Hospital-Specific Limit Methodology, and §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care.

BACKGROUND AND PURPOSE

HHSC has operated portions of the Medicaid program under the authority of an 1115 Healthcare Transformation and Quality Improvement Demonstration Waiver (1115 Waiver) since 2011. When the 1115 Waiver began, Texas received authority for Medicaid-managed care for several populations of existing Medicaid beneficiaries as well as expenditure authority for two supplemental funding pools - the Delivery System Reform Incentive Payment (DSRIP) Program and the Uncompensated Care (UC) Program. The non-federal share of the payments was funded using primarily local funds matched with federal Medicaid funds. Payments were valued based on allocations that were made early in the waiver development process and were based upon projects, and then achievement, not the utilization of Medicaid services. When the waiver was renewed in 2017, the Special Terms and Conditions of the 1115 Waiver required Texas to reduce expenditures through DSRIP before ultimately ending the DSRIP program on September 30, 2021.

HHSC planned successor financial programs that were referred to collectively as the "DSRIP Transition." Through these successor financial programs, HHSC was able to fully replace (and exceed) the total Medicaid expenditures that would have been lost due to the end of DSRIP. This overall maintenance of funding in the health care system is important because the overall economic stability of Texas is not projected to be negatively impacted by the DSRIP Transition. However, complicating the DSRIP Transition, the COVID-19 global pandemic overlapped with the time frame and caused provider market instability and fundamental shifts in historically stable utilization. As a result of various limitations on expenditures and reimbursements contained within various federal statutes and regulations, HHSC was unable to replace expenditures on a per-provider or even a per-class basis, and the regional impact of the transition has resulted in disparate impacts in rural and urban markets.

DSRIP's endurance as a payment mechanism in the health care system in Texas for 10 years resulted in a reliance on those funds for many participating providers to not just incentivize performance, but to finance their underlying infrastructure and cover costs. For hospitals, DSRIP was one of several funding streams that providers relied on, and the transition from DSRIP to successor programs resulted in significant shifts among providers. For some rural hospitals and large urban public hospitals, their current payment projections for fiscal year 2022 and after are not equivalent to their payment levels under DSRIP. This difference is largely a result of all successor programs being based in some manner on Medicaid beneficiary utilization, rather than an allocation basis.

HHSC's approach to the DSRIP Transition was to create programs that were related to the delivery of Medicaid services. Given that Medicaid managed care is the Medicaid model through which the majority of services are delivered, HHSC focused efforts on the modification or creation of directed payment programs (DPPs) that would enable HHSC to increase payments to providers up to their average commercial reimbursement .

Understanding that programs and payments are interlinked due to the successive nature of how uncompensated costs are calculated, HHSC intended to move successively through each program in the payment flow to determine whether modifications or the creation of new programs were appropriate to support the DSRIP Transition. However, due to significant delays in the approval of the DPPs planned for the DSRIP Transition, these efforts were largely paused until a time when HHSC would have more certainty about the landscape of approved payments. Following the approval of the Comprehensive Hospital Increase Reimbursement Program (CHIRP), the Texas Incentives for Physicians and Professional Services (TIPPS), and the Rural Access for Primary and Preventive Services (RAPPS) in March 2022, HHSC began focusing efforts quickly on getting the programs implemented and reinvigorating efforts to examine the other programs. HHSC pursued a Medicaid state plan amendment (SPA) to create a new fee-for-service program, the Hospital Augmented Reimbursement Program, to act as a mechanism to increase reimbursements for public hospitals. Centers for Medicare & Medicaid Services (CMS) approved the SPA for public hospitals on August 31, 2022.

Now that the Medicaid payments for services delivered to Medicaid beneficiaries have been established, HHSC is moving in succession to examine modifications that may be necessary to the Disproportionate Share Hospital (DSH) program, as well as UC. Both of these programs incorporate payment limits in the allocation of the program pools, which HHSC has termed the State

Payment Cap for the interim calculation and the Hospital-Specific Limit, a federally determined cap for audit and reconciliation.

HHSC had many requests from stakeholders related to potential modifications for DSH or UC and HHSC examined these programs in their entirety with the intent of ensuring that the funds are allocated in accordance with their purpose, where the funds were most likely to benefit a large number of Texans receiving care, and in accordance with established state policy goals. HHSC examined each proposed change against the framework of the following goals:

-no financial harm to state entities;

-maintain or increase payments to Rural Hospitals, if possible;

-limit the potential for recoupments of funds at the time of audit or reconciliation;

-ensure compliance with federal laws and regulations and state laws;

-sustainability of program structures, if federal reductions to DSH are ever implemented;

-increase clarity of the regulations;

-increase transparency of the existing administrative practices; and

-sustain long term stability in the financing of the programs.

To the greatest extent possible, HHSC believes the proposed modifications to the rules adhere to those goals, while also ensuring that as many hospitals as possible receive sufficient payments to achieve financial stability and continue providing services to Medicaid clients and uninsured Texans.

State Payment Cap

From 1993 to 2012, Section 1923 (g)(1)(A) of the Social Security Act (SSA) limited a hospital's payments to no more than "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under [the Medicaid Act], other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year." This definition describes the federal Hospital Specific Limit (HSL), the maximum amount a hospital can be reimbursed for the cost of services provided to Medicaid and uninsured patients. It is the sum of the Medicaid shortfall and the hospital's unreimbursed costs of services to the uninsured. The HSL limits payments to hospitals in DSH and UC at the time of the audit or reconciliation, respectively. A higher HSL means a higher potential payment from one or both of those programs. Both programs have a set amount of funds that may be distributed in a program year.

Consequently, a hospital's DSH and UC payment was also dependent (to a certain extent) on the size of its HSL relative to the HSLs of other hospitals in those programs. Section 1923(g) of the SSA has limited DSH payments to the HSL since 1993. The uninsured component of the calculation has not changed. Until 2010, HHSC calculated the Medicaid shortfall component using Medicaid claim and payment data submitted to Texas Medicaid and Healthcare Partnership (TMHP). Only costs associated with submitted claims were included; only Medicaid payments offset those costs. However, CMS issued guidance in the form of answers to Frequently Asked Questions (FAQs) in January 2010 that interpreted Section 1923(g) to require that private insurance payments and Medicare payments offset costs in the HSL calculation. CMS' response to FAQ 33 instructed that all costs and payments associated with Medicaid-eligible patients, who were also covered by private insurance, must be included in the HSL calculation. This guidance primarily impacted children's hospitals because they serve many children who are presumptively eligible for Medicaid based on low birth weight or catastrophic illnesses, without regard to family income or insurance coverage. As a result, many low-weight babies and children with disabilities may have family coverage even if they are also eligible for Medicaid. If the insurer pays for care at rates higher than the reported Medicaid cost, the insurance payment then acts to offset the uninsured or Medicaid shortfall costs of other patients.

FAQ 34 instructed that costs and payments for patients dually eligible for Medicare and Medicaid must be included. This guidance primarily impacted hospitals with high Medicare populations - i.e., those that serve a lot of dual-eligible patients. In response to CMS' guidance, HHSC revised the data it collected from hospitals to calculate the HSL for interim payments and the DSH audit. Starting in 2011, HHSC reduced hospitals' costs for the DSH program by their total private insurance and Medicare payment amounts, thus lowering their DSH or UC payments. This method of calculating costs is frequently referred to as a "full-offset" methodology.

In December 2014, Texas Children's Hospital (TCH) filed suit against CMS in federal district court in the District of Columbia (D.C.) challenging FAQ 33. TCH successfully obtained a temporary injunction. CMS was enjoined from enforcing, applying, or implementing FAQ 33 and from taking any action to recoup federal DSH funds based on a state's noncompliance with the policy. The definition at issue was one in which costs for Medicaid-secondary clients would be included, but any payments from third-party payors would not. This method is frequently referred to as a "no offset" methodology. In August 2016, CMS proposed a rule requiring that Medicare and other third-party insurance payments be considered when determining costs for calculating the HSL for DSH program payments. The rule codified CMS' interpretation of Section 1923(g) as articulated in FAQs 33 and 34 and CMS' arguments in various courts. The rule was to become effective June 2, 2017.

In addition to the TCH lawsuit, numerous lawsuits were filed in federal district courts challenging FAQs 33 and 34 and CMS' final rule. Courts issued preliminary injunctions against CMS in some cases and permanent injunctions when the cases were decided on the merits. On February 21, 2018, Doctors Hospital of Renaissance filed suit against CMS in the United States District Court for D.C. challenging FAQ 34 and the final rule. In May 2017, The Children's Hospital Association of Texas (CHAT) and four free-standing children's hospitals located in Minnesota, Virginia, and Washington filed suit in the United States District Court for D.C. alleging that CMS' final rule was contrary to the Medicaid Act. On March 2, 2018, the court ruled in favor of the plaintiffs and vacated the rule. On March 6, 2018, the court issued its memorandum opinion explaining the decision. The court determined that Section 1923(g), on its face, does not authorize including Medicare payments and private payments in the DSH limit calculation. The court vacated the rule and applied the decision to CMS nationwide; not just to plaintiffs.

On November 4, 2019, the 8th Circuit Court of Appeals ruled in favor of CMS and its final rule implementing FAQs 33 and 34. The decision was consistent with the August 2019 holding by the D.C. Circuit Court of Appeals that ruled against CHAT and

reversed the decision of the United State District Court for the District of Columbia. The final rule's effective date was retroactive, to June 2, 2017.

On December 27, 2020, the Consolidated Appropriations Act for 2021 was signed into law. Included within the legislation was a federal statutory change to remove the cost and payments of individuals with Medicare or third-party coverage from the definition and calculation of the HSL. This definition is commonly referred to as the "MACPAC" definition.

However, in Texas, two payment caps exist for hospitals that participate in DSH and UC. The HSL and the state payment cap (SPC), previously known as the interim HSL, that HHSC may define. The SPC is calculated in the payment year for DSH and UC but the federal payment cap is calculated two years after the payment year using updated data. HHSC had previously linked the interim HSL to the final HSL so there would be a limited chance that recoupment would occur after the final HSL was calculated. Due to the ongoing changes to the HSL, HHSC implemented an SPC that is wholly defined by the state and utilizes the full-offset methodology.

At the time that HHSC chose to define the SPC using the full-offset methodology, the HSL was similarly defined as using a full-offset methodology. Beginning in 2021 when the federal HSL definition moved to largely reflect the "MACPAC" methodology (described above), the two definitions diverged. Subsequently, HHSC has seen a large number of recoupments at the time of the audit or reconciliation of DSH or UC due to this divergence. These recoupments have most significantly impacted rural and state-owned institutions. As a result, maintaining the SPC definition as currently defined would be contrary to HHSC's stated goals for this project.

HHSC is proposing modifying the SPC to become a dual-calculation limitation. This new definition of SPC would be the lesser of two payment ceilings. The first payment ceiling will be the Full-Offset Payment Ceiling. This payment ceiling will use the full-offset methodology to identify costs related to Medicaid and uninsured individuals where there are no revenues associated with any Medicaid or uninsured individuals available to pay for those expenditures. The second payment ceiling will be the Recoupment Prevention Payment Ceiling. This payment ceiling will use the federal HSL calculation to identify costs that are able to be reimbursed, but without inclusion of costs or payments that would not be considered during the audit or reconciliation. From this two-pronged approach to establishing the payment cap, HHSC will meet the goals established above of limiting the potential for recoupments, while also balancing the importance of financial stability for hospitals serving large portions of Medicaid clients or uninsured persons.

Disproportionate Share Hospital Program

DSH payments are authorized by federal law to provide hospitals that serve a large share of Medicaid and low-income patients with additional funding. DSH payments are supplemental payments to help cover more of the cost of care for Medicaid and low-income patients. These payments cannot exceed a hospital's uncompensated costs for both Medicaid-enrolled and uninsured patients. DSH payments are the only Medicaid payment in federal law that is explicitly for paying the unpaid costs of care for uninsured patients. It can be used by states to offset or make up for low Medicaid base payments. However, it is affected by Medicaid base payments and other supplemental funding. For example, an increase to a hospital's base Medicaid payment and its other non-DSH supplemental funding may decrease a hospital's Medicaid shortfall, resulting in a reduction in its uncompensated care costs for which DSH pays.

DSH program payments are made by HHSC to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for total statewide DSH payments made to hospitals. Federal law also limits FFP for DSH payments through the hospital-specific DSH limit. In Texas, the state has established a State Payment Cap that limits the amount of payments that a provider receives through the interim payment process. This proposal amends the definition of the rural provider classes, establishes a new rural DSH pool, describes a methodology for redistribution of certain recouped funds, modifies the calculation of the Low-Income Utilization Rate to reflect federal law, updates the calculation of the State Payment Cap and payment allocation methodology, establishes changes to qualifications of the program and makes other clarifying amendments.

This rule amendment will establish an allocation methodology that is separate from the SPC to allocate Pool 2 as a payment up to a percentage of overall costs. The method will consider hospitals' payment to cost ratio against the set percentage. Hospitals will receive payment based on a set percentage of their total costs after consideration of payments. DSH is the only Medicaid reimbursement option that remains to reimburse for any uncompensated Medicaid costs or non-charity uncompensated care. As such, providers who have high levels of non-Medicaid utilization, which is common among rural and large public providers, may benefit from a method that considers the unique opportunity for reimbursement available under DSH. Additionally, a reimbursement methodology that considers the proportion of total costs covered could help providers achieve more similar percentages of total costs reimbursed.

The low-income utilization rate (LIUR) is a ratio that represents the hospital's volume of inpatient charity care relative to total inpatient services. As currently defined, several providers have a LIUR over one hundred percent, and the rule is being amended to address this. The rule is also being amended to align state LIUR definition with the federal definition, and to specify the use of LIUR for qualification purposes only.

The current rule provides that HHSC can redistribute recouped funds to eligible providers but does not describe the method of the calculation. This rule amendment will provide details of the redistribution methodology and describes two methods of calculation. The first method was formerly used in DSH years 2011-2017 and will continue to be implemented for DSH year 2020 and after and would redistribute funds proportionately to remaining Hospital Specific Limit (HSL) room for eligible hospitals. The rule amendment will also describe a second method used during DSH years 2018-2019 where recouped funds from non-state providers were redistributed to eligible providers using a weighted allocation methodology.

HHSC is incorporating this methodology for calculating payment redistributions to increase transparency regarding the existing practice.

HHSC is removing Children's Hospitals as a deemed ownership type to align with the federal rule which only provides exemption from the Two-Physician requirement in the conditions of participation. With this rule amendment, Children's Hospitals will be required to meet all eligibility criteria, continue to meet at least

one qualification criteria and meet all the conditions of participation.

This rule amendment will also create a new condition of participation. Beginning in DSH program year 2024, providers, with the exception of rural hospitals, will be required to participate in all voluntary Medicaid programs that they are eligible for (e.g., CHIRP, public HARP, GME) in order to participate in DSH. This change will provide safeguard for the state share funding mechanism of the program and as a result ensure the stability of the DSH program.

The recommendation from the 2021 DSH workgroups to add level one trauma hospitals as a category of hospitals that Texas will deem for DSH qualification is not being pursued currently, although providers are welcome to provide public comment on the topic.

This amended rule will update the DSH rural definition to match the Hospital Inpatient Reimbursement rule §355.8052 and establish a new rural DSH pool. This change is intended to provide increased clarity regarding what hospitals are considered rural in the Medicaid program. Within the DSH program allocations, there is an opportunity for certain public hospitals to receive payments through "Pass 3." Pass 3 was intended to allow certain public hospitals an additional opportunity to receive DSH funding for which there was not another source of non-federal share funding available. However, a lack of non-federal share funds has not occurred in recent years, but HHSC has understood that rural hospitals in particular had come to rely on Pass 3 for DSH funding. Therefore, HHSC has been setting aside funds for Pass 3 for several years for this express purpose.

To more transparently and clearly achieve this purpose, HHSC is proposing the creation of a rural DSH sub-pool for hospitals that meet the same definition of rural in the inpatient reimbursement are categorized. The amount of the sub-pool will be equivalent to the amount that has been reserved for Pass 3 in recent years.

The definition for inflation update factor was previously erroneously removed and will be added back to the DSH rule with this amendment. The definition for ratio of cost-to-charges has been updated to include inpatient and outpatient data. HHSC has added a definition for Tax Revenue which has not been historically defined. The term Total state and local payments has been updated to Total state and local subsidies and now includes inpatient and outpatient care to match the federal DSH rule.

Some institution for mental diseases providers have raised a concern about in lieu of services where an MCO pays for services delivered to clients in the 21-64 age range but the costs and payments for these services are not currently included in DSH. HHSC is not amending the rule related to this topic but is interested in receiving comments on this issue.

Uncompensated Care Program

UC payments to hospitals are authorized under Section 1115 demonstrations. UC payments originated as a way for Texas to continue to expand managed care in Medicaid programs and continue making supplemental payments to hospitals. States negotiate the parameters of their UC pools with CMS. Texas UC payments may be used to reduce the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity care policy. The medical services must meet the definition of "medical assistance" as defined in federal law.

Under the terms of the January 15, 2021 1115 Waiver, HHSC negotiated for the continuation and resizing of the UC pool. The result of the first pool resizing is an increase in the pool by approximately $600 million annually, for a total of $4.5 billion for demonstration years 12 through 16. This expenditure authority may be utilized only for providers that are authorized to participate in UC who demonstrate charity care expenses. HHSC recommends that the new, additional UC funding be considered for a different allocation methodology than the previously extant $3.9 billion. HHSC proposes defining this sub-pool as the High Impecunious Charge Hospital (HICH pool). Eligibility to receive funds from this pool would be restricted to rural hospitals, state-owned hospitals, and hospitals that have at least 30 percent of their charges from serving uninsured persons. HHSC is proposing using 30 percent of charges as this threshold represents a very small number of hospitals - indicating that 30 percent is truly rare and a high portion of charges. However, HHSC is interested in receiving comments on whether a different percentage than 30% should be considered. This will target these funds to hospitals that serve a large volume of uninsured persons as part of their patient-mix as well as rural hospitals and state-owned facilities, consistent with HHSC's established goals.

In addition, the proposed update removes the Regional Health Partnership (RHP) eligibility requirement that is no longer in effect as the RHP is no longer in operation with the discontinuation of DSRIP.

Clarifying Amendments

Throughout all three rules, HHSC has attempted, when possible, to align definitions, remove references to DSRIP or DSRIP-related requirements, and make other changes for clarity and ease of reading.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8065(b) adds the definition for "inflation update factor" as it was erroneously deleted. The definition for "non-rural hospital" is added, which is any hospital that does not meet the definition of rural hospital in the inpatient rule definition from §355.8052. The definition for "Public Health Hospital" is added. The definition for "State-owned teaching hospital," is added, which refers to the definition in the inpatient hospital rule §355.8052. The definition for "Tax Revenue" is added to define a term that has been used in the program but has not been in the Texas Administrative Code.

The definition for "rural public-financed hospital" is deleted; it has been combined with rural public hospital. The definition for "state chest hospital," "urban public hospital," and "urban public hospital - Class two" is deleted.

The proposed amendment to §355.8065(b) updates the definition for "Children's hospital" to refer to the inpatient rule definition from §355.8052. The definition for "institution for mental disease (IMD)" is updated to refer to the Social Security Act and freestanding psychiatric facility rule §355.8060. The definition for "non-urban public hospital" is updated. The definition for "Ratio of cost-to-charges" is updated to include inpatient and outpatient data.

The proposed amendment to §355.8065(b) updates the definition for "Rural public hospital" to match the inpatient rule definition of rural from §355.8052, defines public hospital in subparagraph (A), and defines public-financed in subparagraph (B). The definition for "State Institution for mental diseases" is updated to reference the Social Security Act and freestanding psy-

chiatric rule §355.761. The definition for "State-owned hospital" is updated to refer to the definitions of "state IMD," "state-owned teaching hospital," and "public health hospital."

The proposed amendment to §355.8065(b) updates the term "Total state and local payments" to "Total state and local subsidies" to match the federal terminology. The amendment adds inpatient and outpatient data and includes tax revenue within the term. The definition for "urban public hospital--Class one" is updated to "transferring public hospital."

The proposed amendment to §355.8065(c)(3)(E) adds clarification that for mergers, data will be merged if liabilities are assumed through the merger agreement.

The proposed amendment to §355.8065(d)(2) updates the low-income utilization rate calculation to match the federal LIUR calculation. The proposed amendment to §355.8065(d)(4) deletes the term "Children's hospitals" from being deemed to qualify as this ownership type is not federally deemed and deletes state chest hospitals and state IMDs as these are already included in the definition of state-owned hospitals. The proposed amendment to §355.8065(d)(5) adds clarification that merged hospitals must meet the requirements of subsection (c)(3)(E).

The proposed amendment to §355.8065(e)(3)(C) adds Public Health Hospitals as exempt from the trauma condition of participation to align with current practice. Section 355.8065(e)(8) updates the "Rate Analysis Department" to "Provider Finance Department." New paragraph (9) is added to §355.8065 to add a new condition of participation: Participation in all voluntary Medicaid programs. This will be a new requirement for all non-rural DSH participants except for state-owned hospitals starting in FFY 2024.

The proposed amendment to §355.8065(g)(1) renames the paragraph "state-owned hospitals" and revises state chest hospitals to public health hospitals. Section 355.8065(g)(2) is revised to establish a set aside amount for rural public providers. Paragraph (g)(3) is updated to rename the paragraph from "other hospitals" to "non-state hospitals." This update aligns the rule text with the calculation file tabs. Clarification is also added that rural public hospitals are eligible for this amount, and in subparagraph (A), that the non-state allocation is after both (1), the state, and (2), the rural public distribution.

The proposed amendment to §355.8065(h) adds an additional data verification criterion in paragraph (1)(A), data sources, to give providers approved data sources for the application submission. Subsection (h)(2) is updated to include "for non-state hospitals." Subsection (h)(2)(B)(ii) updates "urban public hospital" to "transferring public hospital," adds the term "or non-urban" and deletes the word "rural," and "rural public financed hospital." The proposed amendment to §355.8065 deletes (h)(2)(C)(iii)(I) urban public hospitals -class two since this class is no longer included in the rule. Subsection (h)(2)(C)(iii)(I) non-urban public hospitals updates the language to not include pool two pass one and pass two, since the second pass will not be necessary with a percentage of cost covered methodology, and the conditions of general revenue shortage was removed. The proposed amendment to §355.8065 (h)(2)(C)(iii)(II) updates "urban public hospitals--class one" to "transferring public hospitals," and eliminates pool two pass two, since the second pass will not be necessary with a percentage of cost covered methodology.

The proposed amendment to §355.8065(h) replaces paragraph (3), weighting factors, with new paragraph (3), Calculation of percentage of cost covered. Subsection (h)(4) is renamed from "Pass One distribution and payment calculation for Pools One and Two" to "Distribution and payment calculation for Pools One and Two." The amendment also updates the methodology throughout the paragraph to explain how the percentage of cost covered will be applied to the Pool One and Two calculation. Paragraph (5), Pass Two for Pool One and Two, is deleted since the second pass will not be necessary with a percentage of cost covered methodology. Paragraph (6) is renumbered to paragraph (5) and several updates are made including updating the hospital classes and removing references to pool one and pool two pass two. New paragraph (7), Rural public hospital pool distribution and calculation. This paragraph describes how to distribute the rural public allocation among the rural public hospitals based on remaining percentage of cost covered. Paragraph (8) updates the Pass Three to include, "Pass Three - if any portion non-federal share of the available DSH funds is not fully funded, the remaining allocation will be available to non-urban public hospitals that met the funding requirements described in paragraph (2)(C) of this subsection." It also updates rural public and rural public-financed to the term non-urban public. Paragraph (9), Reallocating funds if hospital closes, loses its license or eligibility, or files bankruptcy, is updated to note that state hospitals receive reallocated funds first, followed by all other DSH hospitals. This was updated to align with current practice. Paragraph (11) is revised to describe the procedure of first reducing non-state IMDs by a pro-rata reduction in the event that the sum of the annual payment amounts for state owned and non-state owned IMDs exceed the annual Federal IMD limit.

The proposed amendment to §355.8065 (i) adds state natural disaster area to the subsection.

The proposed amendment to §355.8065(k)(5) revises the department name from "Rate Analysis Department" to "Provider Finance Department" and updates "Director of Hospital Rate Analysis" to "Director of Hospital Finance."

The proposed amendment to §355.8065 adds subsection (p) Redistribution of recouped funds in order to document and align the rule with current practice.

The proposed amendment to §355.8066 renames the section "State Payment Cap and Hospital-Specific Limit Methodology." Subsection (a), Introduction, is updated to include reference to §355.8212, Waiver Payments to Hospitals for Uncompensated Charity Care.

The proposed amendment to §355.8066(b) adds a definition for "Demonstration Year," "DSH and UC Application Request Form," "Federal Fiscal Year (FFY)," "Full-Offset Payment Ceiling," "Medicaid payor type," "Recoupment Prevention Payment Ceiling," and "Uncompensated Care Hospital."

The proposed amendment to §355.8066(b) deletes the definition for "Non-DSH survey" and "Ratio of cost-to-charges."

The term "DSH survey" is replaced with "DSH and Uncompensated Care (UC) Application" to match the terminology used and the definition is updated. The proposed amendment updates subsection (b)(12), Hospital-specific limit, to include reference to Section 1923(g) of the Social Security Act, add clarifying language, and remove the mention of "Delivery System Reform Incentive Payment" as the program no longer exists. The definition for "Institution for mental diseases (IMD)" is updated. The definition for Outpatient charges is updated to change language for "hospital specific limit" to "a payment cap or limit."

The proposed amendment to §355.8066(b) updates the definition for "State payment cap" to remove the mention of "Delivery System Reform Incentive Payment" as the program no longer exists and to clarify language. The term "Total state and local payments" is updated to "Total state and local subsides" to align with the definition in §355.8065.

The proposed amendment to §355.8066(c), Calculating a state payment cap, updates the subsection by removing the words "hospital-specific limit," replacing the term "DSH or non-DSH survey" with "DSH and UC Application," and clarifying paragraph references and language.

The proposed amendment to §355.8066(c)(1) replaces the phrase "State Payment Cap" with "Calculation of uninsured and Medicaid costs and payments," the term "survey" is replaced with "application", and state and local "payments" with "subsidies." The proposed amendment to §355.8066(c)(1) adds directed payments as an adjustment factor that can be applied to Medicaid payment data to align with current practice. The paragraph has been reorganized for clarity.

The proposed amendment to §355.8066(c)(1)(D) replaces "calculation of the state payment cap" with "calculation of the full-offset payment ceiling" to clearly explain the payments, costs, and inflator used for this payment ceiling. The amendment to §355.8066(c)(2), which is renumbered as (c)(3), replaces "Hospital-specific limit" with "Calculation of the Recoupment Prevention Payment Ceiling" to explain the methodology for the new recoupment prevention payment ceiling used in Federal Fiscal Year 2023 and forward to prevent recoupments. New subparagraph (c)(4), State Payment Cap, explains the new state payment cap for Federal Fiscal Year 2023 and forward and to preserve the previous definitions of state payment cap used in years before Federal Fiscal Year 2023. New subparagraph (d), Hospital-Specific Limit, updates references and adds a procedure for requesting a federally authorized exception to the HSL calculation.

The proposed amendment to §355.8066(d) replaces the phrase "Due date for DSH or non-DSH survey" with "Due date for DSH and UC Application," the term "Rate Analysis" with "Provider Finance Department," and the term "survey" with "application."

The proposed amendment to §355.8066(e) updates the term "DSH or non-DSH survey" to "DSH and UC Application," adds "unless it is related to exceptions permitted by Section 1923(g) of the Social Security Act" as an applicable category of data that providers can request a review for, and adds the uncompensated care payment amounts in §355.8212 as a category that HHSC will not consider for a review request.

The proposed amendment to §355.8212(b) deletes the definition for "Affiliation Agreement," "Anchor," "Delivery System Reform Incentive Payments (DSRIP)," "Large public hospital," "Regional Healthcare Partnership (RHP)," and "RHP plan."

The proposed amendment to §355.8112(b) adds definitions for "Impecunious charge ratio," "Medicaid cost report," "Non-public hospital," "Public Health Hospital (PHH)," "State institution for mental diseases (State IMD)," "State-owned hospital," "State-owned teaching hospital," "State Payment Cap," and "Transferring public hospital."

The proposed amendment to §355.8212(b) updates the definition for "Disproportionate Share Hospital (DSH)" to add a reference to §355.8065 and the definition for "Institution for mental diseases (IMD)" to add a reference to §1905(i) of the Social Security Act, §355.8060, and §355.761.

The proposed amendment to §355.8212(b) updates the definition for "Uncompensated-care payments" to remove reference to paragraph (5) of the subsection to improve clarity of the definition.

The proposed amendment to §355.8212(c) deletes paragraph (1)(B) to remove language relating to affiliation agreements, anchors, and certification requirements that are no longer applicable and adds new language to describe the UC application fee for non-public providers and to describe the requirement for all non-rural hospitals, except for state hospitals, to enroll, participate and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs in order to participate in the UC program.

The proposed amendment to §355.8212 updates subsection (c)(2) to remove subparagraph (B), the RHP eligibility requirement and the content in subsection (c)(2)(A) is combined into paragraph (c)(2).

The proposed amendment to §355.8212(c)(3) removes the RHP eligibility requirement, reference to affiliation, and adds subparagraph (C) to provide details and requirements for merging data in the UC program.

The proposed amendment to §355.8212(f)(2)(A) describes UC pools in each demonstration year and establishes a high impecunious charge hospital (HICH) pool effective Demonstration Year 12 and forward. The amendment to paragraph (2)(B)(i) makes a reference to the new state-owned hospital definition in subsection (b). The amendment to subsection (f)(2)(D) defines eligible hospitals for the high impecunious charge hospital (HICH) pool and describes the calculation methodology for the pool amount. Subsection (f)(2)(E) is updated to accurately reflect reference to subparagraphs "(B)-(D) of this paragraph" following rule text changes.

The proposed amendment to §355.8212(g)(2)(A)(iv) updates "large hospital" to "transferring hospitals" and removes reference to "affiliation agreement" that is no longer valid. Subsections (g)(3)(A) and (g)(3)(B) are updated to change "CMS 2552-10" cost report to "Medicaid" cost report for clarity and consistency across rules. Subsection (g)(6)(B)(i) is updated to clarify that the payment data point includes the advance payments described in paragraph (9) of the subsection.

The proposed amendment to §355.8212 updates subsections (h)(1)(A) to add the word "maximum" to payment amount to clarify language. Subsection (h)(2) is updated to remove reference to "affiliation" which is no longer valid.

Along with these edits, editorial revisions are made to update numbering, references, and punctuation.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed rules will expand 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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules due to the avoidance of recoupments that might otherwise occur, improved alignment of payments with their intended purpose, and increased transparency with the new details included in the rules.

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

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

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

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Christina Nip in the HHSC Provider Finance for Hospitals department at pfd_hospitals@hhsc.state.tx.us.

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) e-mailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When e-mailing comments, please indicate "Comments on Proposed Rule 23R021" in the subject line.

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8065, §355.8066

STATUTORY AUTHORITY

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

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

§355.8065. Disproportionate Share Hospital Reimbursement Methodology.

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

(b) Definitions.

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

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

limited to the portion of funds identified by HHSC for that partial payment.

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

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

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

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

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

(8) Children's hospital--A hospital that is a Children's hospital as defined in §355.8052 of this chapter (relating to Inpatient Hospital Reimbursement). [~~A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.~~]

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

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

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

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

(13) 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.

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

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

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

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

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

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

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

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

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

(23) [~~(22)~~] Low-income days--Number of inpatient days attributed to indigent patients, calculated as described in subsection (h)(4)(A)(ii) of this section.

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

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

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

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

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

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

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

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

(32) Non-rural hospital--Any hospital that does not meet the definition of rural hospital as defined in §355.8052 of this chapter.

(33) [~~(31)~~] Non-urban public hospital--A hospital other than a transferring public hospital that is: [~~A rural public-financed hospital, as defined in paragraph (37) of this subsection, or a hospital owned and operated by a governmental entity other than hospitals in Urban public hospital - Class one or Urban public hospital - Class two.~~]

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

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

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

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

(36) [~~(34)~~] 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.

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

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

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

(A) owned and operated by a governmental entity; or [~~that is located in a county with 500,000 or fewer persons, based on the most recent decennial census~~]

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

[~~(37) Rural public-financed hospital--A hospital operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons, based on the most recent decennial census, where the hospital and governmental entity have both signed an attestation that they wish the hospital to be treated as a public hospital for all purposes under both this section and §355.8201 of this title (relating to Waiver Payments to Hospitals for Uncompensated Care).~~]

[~~(38) State chest hospital--A public health facility operated by the Department of State Health Services designated for the care and treatment of patients with tuberculosis.~~]

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

(41) [~~(40)~~] State-owned hospital--A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in this section [~~owned and operated by a state university or other state agency~~].

(42) State-owned teaching hospital--A hospital that is a state-owned teaching hospital as defined in §355.8052 of this chapter.

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

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

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

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

(A) The term includes:

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

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

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

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

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

(B) The term excludes:

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

(ii) days denied for late filing and other reasons; and

(iii) days for dually eligible patients for purposes of the following calculations:

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

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

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

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

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

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

~~[(46) Urban public hospital--Any of the urban hospitals listed in paragraph (47) or (48) of this subsection.]~~

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

~~[(48) Urban public hospital - Class two--A hospital operated by or under a lease contract with one of the following entities: the Ector County Hospital District, the Lubbock County Hospital District, or the Nueces County Hospital District.]~~

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

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

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

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

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

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

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

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

(E) Merged Hospitals.

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

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

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

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

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

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

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

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

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

~~[(A) The low-income utilization rate is the sum (expressed as a percentage) of the fractions calculated in clauses (i) and (ii) of this subparagraph:]~~

~~*[(i)* The sum of the total Medicaid inpatient hospital payments and the total state and local payments paid to the hospital for inpatient care in the DSH data year, divided by a hospital's gross inpatient revenue multiplied by the hospital's ratio of cost-to-charges (inpatient only) for the same period: (Total Medicaid Inpatient Hospital Payments + Total State and Local Payments)/(Gross Inpatient Revenue x Ratio of Costs to Charges (inpatient only)).]~~

~~*[(ii)* Inpatient charity charges in the DSH data year minus the amount of payments for inpatient hospital services received~~

directly from state and local governments, excluding all Medicaid payments, in the DSH data year, divided by the gross inpatient revenue in the same period: (Total Inpatient Charity Charges - Total State and Local Payments)/Gross Inpatient Revenue).]

[(B) HHSC will determine the ratio of cost-to-charges (inpatient only) by using information from the appropriate worksheets of each hospital's Medicaid cost report or reports that correspond to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available submitted Medicaid cost report or reports.]

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total Medicaid inpatient days for all hospitals participating in the Medicaid program, except a[;]

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

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

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

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

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

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

(1) Two-physician requirement.

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

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

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

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

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

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

(3) Trauma system.

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

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

(C) The following hospital types are exempted from the condition of participation described in this paragraph: Children's Hospitals, IMDs, Public Health Hospitals, and State IMDs.

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

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

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

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. If HHSC receives documents verifying the merger status with Medicare

prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

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

(9) Participation in all voluntary Medicaid programs. Beginning in Federal Fiscal Year (FFY) 2024, it will be required for all non-rural hospitals, except for state-owned hospitals, to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in DSH.

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

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

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

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

(3) [~~(2)~~] Non-state [~~Other~~] hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section, including rural public hospitals.

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

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

(h) DSH payment calculation.

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

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

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

(C) [~~(B)~~] an opportunity for hospitals to request HHSC review of disputed data.

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

(A) Pool One.

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

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

(B) Pool Two.

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

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

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

(ii) Pool Two payments are available to all non-state-owned hospitals except for any transferring public hospitals [~~urban public hospital~~] as defined in subsection (b)[~~(46)~~] of this section; or non-urban [~~rural~~] public hospital as defined in subsection (b)[~~(36)~~] of this section[~~; or rural public-financed hospital as defined in subsection (b)(37) of this section owned by or affiliated with a governmental entity~~] that does not transfer any funds to HHSC for Pool Three as described in subparagraph (C)(iii) of this paragraph.

(C) Pool Three.

(i) Pool Three is equal to the sum of intergovernmental transfers for DSH payments received by HHSC from governmental entities that own and operate transferring public hospitals [~~Urban public hospitals - Class one, governmental entities that operate or are under lease contracts with an Urban public hospital - Class two,~~] and non-urban public hospitals.

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

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

~~*[(I)* Urban public hospitals - Class two. Each governmental entity that operates or is under a lease contract with an Urban public hospital - Class two is responsible for funding an amount equal to the non-federal share of Pass One and Pass Two DSH pay-~~

ments from Pool Two (calculated as described in paragraphs (4) and (5) of this subsection) to that hospital.]

(I) [(II)] Non-urban public hospitals.

[(-a-)] Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for funding [one-half of] the non-federal share of the hospital's [Pass One and Pass Two] DSH payments from Pool Two (calculated as described in paragraph [paragraphs] (4) [and (5)] of this subsection) to that hospital.

[(-b-) If general revenue available for Pool One does not equal at least one-half of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two, each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for increasing its funding of the non-federal share of that hospital's Pass One and Pass Two DSH payments from Pool Two by an amount equal to the Pool One general revenue shortfall associated with the hospital.]

(II) [(III)] Transferring public hospitals [Urban public hospitals - Class one]. Each governmental entity that owns and operates a transferring public hospital [an Urban public hospital - Class one] is responsible for funding the non-federal share of the [Pass One and Pass Two] DSH payments from Pool Two (calculated as described in paragraph [paragraphs] (4) [and (5)] of this subsection) to its affiliated hospital and a portion of the non-federal share of the [Pass One and Pass Two] DSH payments from Pool Two to private hospitals. For funding payments to private hospitals, HHSC will initially suggest an amount in proportion to each transferring public hospitals' [Urban public hospital - Class one's] individual state payment cap relative to total state payment caps for all transferring public hospitals [Urban public hospitals - Class one]. If an entity transfers less than the suggested amount, HHSC will take the steps described in paragraph (4)(E) [(5)(F)] of this subsection.

(III) [(IV)] Following the calculations described in paragraph [paragraphs] (4) [and (5)] of this subsection, HHSC will notify each governmental entity of its allocated intergovernmental transfer amount.

(3) Calculation of percentage of costs covered.

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

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

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

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

[(3) Weighting factors.]

[(A) HHSC will assign each non-urban public hospital a weighting factor that is calculated as follows:]

[(i) Determine the non-federal percentage in effect for the program year and multiply by 0.50.]

[(ii) Add 1.00 to the result from clause (i) of this subparagraph and round the result to two decimal places; this rounded sum is the non-urban public hospital weighting factor.]

[(iii) If paragraph (2)(C)(iii)(II)(-b-) of this subsection is invoked, the 0.50 referenced in clause (i) of this subparagraph will be increased to represent the increased proportion of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two required to be funded by these hospitals' associated governmental entities.]

[(B) All other DSH hospitals not described in subparagraph (A) of this paragraph will be assigned a weighting factor of 1.00, except for DSH program years beginning before October 1, 2017, HHSC will assign weighting factors as follows to each non-state DSH hospital:]

[(i) Other Insurance Weight. HHSC will divide the amount of third party commercial insurance payments for that hospital from the DSH data year by the state payment cap calculated according to §355.8066(c)(1)(D)(ii)(I)(-b-), except that costs are reduced by payments from all payors.]

[(I) The result, if greater than 1, will be used as a weighting factor.]

[(II) If the result is less than 1, no weighting factor will be applied.]

[(ii) Year-To-Date Payment Weight. HHSC will assign a weighting factor of 20 to any hospital that did not receive any prior payments for that DSH program year. This weighting factor will be added to the weighting factor calculated in clause (i) of this subparagraph.]

(4) Distribution [Pass One distribution] and payment calculation for Pools One and Two.

(A) HHSC will determine an allocation percentage such that all hospitals receive a uniform percentage of their costs covered to fully utilize Pools One and Two. [HHSC will calculate each hospital's total DSH days as follows:]

[(i) Weighted Medicaid inpatient days are equal to the hospital's Medicaid inpatient days multiplied by the appropriate weighting factors from paragraph (3) of this subsection.]

[(ii) Low-income days are equal to the hospital's low-income utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospital's total inpatient days as defined in subsection (b)(18) of this section.]

[(iii) Weighted low-income days are equal to the hospital's low-income days multiplied by the appropriate weighting factors from paragraph (3) of this subsection.]

[(iv) Total DSH days equal the sum of weighted Medicaid inpatient days and weighted low-income days].

(B) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the DSH funding pools for non-state hospitals.

[(B) Using the results from subparagraph (A) of this paragraph, HHSC will:]

[(i) Divide each hospital's total DSH days from subparagraph (A)(iv) of this paragraph by the sum of total DSH days for all non-state-owned DSH hospitals to obtain a percentage.]

[(ii) Multiply each hospital's percentage as calculated in clause (i) of this subparagraph by the amount determined in

paragraph (2)(A) of this subsection to determine each hospital's Pass One projected payment amount from Pool One.]

[(iii) Multiply each hospital's percentage as calculated in clause (i) of this subparagraph by the amount determined in paragraph (2)(B)(i)(I) or (II) of this subsection, as appropriate, to determine each hospital's Pass One projected payment amount from Pool Two.]

[(iv) Sum each hospital's Pass One projected payment amounts from Pool One and Pool Two, as calculated in clauses (ii) and (iii) of this subparagraph respectively. The result of this calculation is the hospital's Pass One projected payment amount from Pools One and Two combined.]

[(v) Divide the Pass One projected payment amount from Pool Two as calculated in clause (iii) of this subparagraph by the hospital's Pass One projected payment amount from Pools One and Two combined as calculated in clause (iv) of this subparagraph. The result of this calculation is the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two.]

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

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

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

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

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

[(5) Pass Two - Redistribution of amounts in excess of state payment caps from Pass One for Pools One and Two combined. In the event that the projected payment amount calculated in paragraph (4)(B)(iv) of this subsection plus any previous payment amounts for the program year exceeds a hospital's state payment cap, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the state payment cap. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals that have projected payments, including any previous payment amounts for the program year, below their state payment caps. For each such hospital, HHSC will:]

[(A) subtract the hospital's projected DSH payment from paragraph (4)(B)(iv) of this subsection plus any previous payment amounts for the program year from its state payment cap;]

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

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

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

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

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

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

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

[(D) If a governmental entity that operates or leases to an Urban public hospital - Class two does not fully fund the amount described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will reduce the hospital's Pass One and Pass Two DSH payment from Pool Two to the level supported by the amount of the intergovernmental transfer.]

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

[(F) If a governmental entity that owns and operates an Urban public hospital - Class one does not fully fund the amount described in paragraph (2)(C)(iii)(III) of this subsection, HHSC will take the following steps:]

[(i) Provide an opportunity for the governmental entities affiliated with the other Urban public hospitals - Class one to transfer additional funds to HHSC;]

[(ii) Recalculate total DSH days for each Urban public hospital - Class one for purposes of the calculations described in paragraphs (4)(B) and (5)(A) - (C) of this subsection as follows:]

[(I) Divide the intergovernmental transfer made on behalf of each Urban public hospital - Class one by the sum of intergovernmental transfers made on behalf of all Urban public hospitals - Class one;]

[(II) Sum the total DSH days for all Urban public hospitals - Class one, calculated as described in paragraph (4)(A) of this subsection; and]

[(III) Multiply the result of subclause (I) of this clause by the result of subclause (II) of this clause to determine total DSH days for that hospital;]

[(iii) Recalculate Pass One payments from Pool Two and Pass Two payments from Pools One and Two for Urban public hospitals - Class one and private hospitals following the methodology described in paragraphs (4)(B) and (5)(A) - (C) of this subsection substituting the results from clause (ii) of this subparagraph for the results from paragraph (4)(A) of this subsection for Urban public hospitals - Class one;]

[(iv) Perform a second recalculation of Pass Two payments from Pools One and Two for Urban public hospitals - Class one as follows:]

[(I) ~~Multiply each hospital's total Pass Two projected payment amount from Pools One and Two from paragraph (5) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph, by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph. The result is the hospital's Pass Two projected payment amount from Pool Two;~~]

[(II) ~~Subtract the hospital's Pass Two projected payment amount from Pool Two from subclause (I) of this clause from the hospital's total Pass Two projected payment amount from Pools One and Two from paragraph (5) of this subsection, after performing the recalculation described in clause (iii) of this subparagraph. The result is the hospital's Pass Two projected payment amount from Pool One;~~]

[(III) ~~Sum the total Pass Two projected payment amounts from Pool Two, calculated as described in subclause (I) of this clause, for all Urban public hospitals - Class one;~~]

[(IV) ~~Multiply the result of clause (ii)(I) of this subparagraph for the hospital by the result of subclause (III) of this clause to determine the Pass Two payment from Pool Two for the hospital; and~~]

[(V) ~~Sum the results of subclauses (II) and (IV) of this clause to determine the total Pass Two payment from Pools One and Two for that hospital; and~~]

[(v) ~~Use the results of this subparagraph in the calculations described in paragraphs (6) and (7) of this subsection.~~]

(5) [~~(6)~~] Pass One distribution and payment calculation for Pool Three.

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

(i) For each transferring public [~~Urban public~~] hospital: [~~- Class one and Class two--~~]

[(I) ~~multiply its total Pool One and Pool Two payments after Pass Two from paragraph (5) of this subsection by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection;~~]

(I) [~~(II)~~] divide the Pool Two payments from paragraph (4) of this subsection [~~result from subclause (I) of this clause~~] by the FMAP for the program year; and

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

(ii) For each Non-urban public hospital:[~~--~~]

[(I) ~~multiply its total Pool One and Pool Two payments after Pass Two from paragraph (5) of this subsection by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from paragraph (4)(B)(v) of this subsection;~~]

(I) [~~(II)~~]divide the Pool Two payments from paragraph (4) of this subsection [~~result from subclause (I) of this clause~~] by the FMAP for the program year; and

(II) [~~(III)~~] multiply the result from subclause (I)[~~(II)~~] of this clause by the non-federal percentage. The result is the Pass One initial payment from Pool Three for these hospitals. [~~and multiply by 0.50. The result is the Pass One initial payment from Pool Three for these hospitals.~~]

[(IV) ~~If paragraph (2)(C)(iii)(II)(-b-) of this subsection is invoked, the 0.50 referenced in subclause (III) of this clause will be increased to represent the increased proportion of the non-federal share of non-urban public hospitals' Pass One and Pass Two DSH payments from Pool Two required to be funded by these hospitals' associated governmental entities.~~]

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

(B) HHSC will calculate the secondary payment from Pool Three for each transferring public [~~Urban public~~] hospital [~~- Class one~~] as follows.[:]

(i) Sum the intergovernmental transfers made on behalf of all transferring public [~~Urban public~~] hospitals [~~- Class one~~].[;]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) HHSC will determine an allocation percentage such that all rural public hospitals receive a uniform percentage of the costs covered to fully utilize the rural public all funds allocation. The percentage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.

(B) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the rural public hospital pool.

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

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

(8) Pass Three - If any portion non-federal share of the available DSH funds is not fully funded, the remaining allocation will be available to non-urban public hospitals [~~additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals~~] that met the funding requirements described in paragraph (2)(C)(iii)(I) [~~(2)(C)~~] of this subsection [~~may be eligible for DSH funds in addition to the projected payment amounts calculated in paragraphs (4) - (7) of this subsection~~].

(A) For each non-urban [~~rural~~] public hospital [~~or rural public financed hospital~~] that met the funding requirements described in paragraph (2)(C)(iii)(I) [~~(2)(C)~~] of this subsection, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with paragraphs (4) - (7) of this subsection, as appropriate.

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

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

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

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) - (7) of this subsection from the amount in subsection (g)(3)[~~(2)~~] of this section;

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

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

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

(E) Non-urban public hospitals [~~Rural public and rural public-financed hospitals~~] that do not meet the funding requirements of paragraph (2)(C)(iii)(I) [~~(2)(C)(iii)(II)~~] of this subsection are not eligible for participation on Pass Three.

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

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

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

(12) For any DSH program year for which HHSC has calculated the hospital-specific limit described in §355.8066(c)(2) of this chapter, HHSC will compare the interim DSH payment amount as calculated in subsection (h) of this section to the hospital-specific limit.

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

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

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

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

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

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

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

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

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

(k) Disproportionate share funds held in reserve.

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

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

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

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

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

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

(i) be sent to HHSC's Director of Hospital Finance [~~Rate Analysis~~], Provider Finance [~~Rate Analysis~~] Department;

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

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

(B) The review is:

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

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

(iii) not conducted as an adversarial hearing.

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

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

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

(n) Voluntary withdrawal from the DSH program.

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

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

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

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

(o) Audit process.

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

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

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

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

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

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

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

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

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

(F) Review of preliminary audit finding of overpayment.

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

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

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

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

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

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

(iii) The review is:

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

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

(III) not an adversarial hearing.

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

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

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

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

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

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

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

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

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

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

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

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

quotient by the total amount of recouped dollars available for redistribution described in subsection (p)(1) of this section.

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

(q) [~~(p)~~] Advance Payments

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

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

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

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

(5) The amount of the advance payments:

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

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

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

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

§355.8066. State Payment Cap and Hospital-Specific Limit Methodology.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate a hospital-specific limit for each Medicaid hospital participating in either the Disproportionate Share Hospital (DSH) program, described in §355.8065 of this division [~~title~~] (relating to Disproportionate Share Hospital Reimbursement Methodology), or in the Texas Healthcare Transformation and Quality Improvement Program (the waiver), described in §355.8201 of this subchapter [~~title~~] (relating to Waiver Payments to Hospitals for Uncompensated Care) and §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

(b) Definitions.

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

(2) Centers for Medicare and 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) Data year--A 12-month period that is two years before the program year from which HHSC will compile data to determine DSH or uncompensated-care waiver program qualification and payment.

(4) Demonstration Year--The time period described in the definition for "Demonstration year" in §355.8212 of this subchapter.

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

(6) [~~(5)~~] DSH and Uncompensated Care (UC) Application [~~survey~~]--The HHSC data collection tool completed by each [~~DSH~~] hospital applying for participation in DSH or UC and used by HHSC to calculate the state payment cap and hospital-specific limit, as described in this section, and to estimate the hospital's DSH and UC payments for the program year, as described in §355.8065 of this division (relating to Disproportionate Share Hospital Reimbursement Methodology) and §355.8212 of this subchapter [~~title~~]. A hospital may be required to complete multiple applications [~~surveys~~] due to different data requirements between the state payment cap and hospital-specific limit calculations.

(7) DSH and UC Application Request Form--An online survey sent to hospitals or its representatives to request a DSH and UC application and to collect information necessary to prepopulate the DSH and UC application.

(8) [~~(6)~~] Dually eligible patient--A patient who is simultaneously enrolled in Medicare and Medicaid.

(9) Federal Fiscal Year (FFY)--The 12-month period beginning October 1 and ending September 30. The period also corresponds to the waiver demonstration year.

(10) Full-Offset Payment Ceiling--The maximum payment cap derived using the full-offset methodology as described in subsection (c)(1) of this section.

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

(12) [~~(8)~~] Hospital-specific limit--The maximum payment amount authorized by Section 1923(g) of the Social Security Act[~~, as applied to payments made during a prior program year,~~] that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured for payments made during a prior program year. The amount is calculated as described in subsection (d) [~~(c)(2)~~] of this section using actual cost and payment data from that period. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage; and costs associated with pharmacies, clinics, and physicians.[~~; or costs associated with Delivery System Reform Incentive Payment projects.~~] The calculation of the hospital-specific limit must be consistent with federal law.

(13) [~~(9)~~] Inflation update factor--Cost of living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.

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

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

(16) [~~(12)~~] Medicaid cost-to-charge ratio (inpatient and outpatient)--A Medicaid cost report-derived cost center ratio calculated for each ancillary cost center that covers all applicable hospital costs and charges relating to inpatient and outpatient care for that cost center. This ratio is used in calculating the hospital-specific limit and does not distinguish between payor types such as Medicare, Medicaid, or private pay.

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

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

(19) Medicaid payor type--The categories of payors on Medicaid claims. These are categorized in the DSH and UC application as Medicaid, where Medicaid is the sole payor, Medicare, for claims associated with the care of dually eligible patients, and other insurance, for claims for which the hospital received payment from a third-party payor for a Medicaid-enrolled patient.

[~~(15) Non-DSH survey--The HHSC data collection tool completed by non-DSH hospitals and used by HHSC to calculate the state payment cap and hospital-specific limit, as described in this section, and to calculate uncompensated care waiver payments for the program year, as described in §355.8201 of this title. A hospital may be required to complete multiple surveys due to different data requirements between the state payment cap and hospital-specific limit calculations.~~]

(20) [~~(16)~~] Outpatient charges--Amount of gross outpatient charges related to the applicable data year and used in the calculation of a payment [~~the hospital specific~~] limit or cap.

(21) [~~(17)~~] Program year--The 12-month period beginning October 1 and ending September 30. The period corresponds to the waiver demonstration year.

[~~(18) Ratio of cost-to-charges.~~]

[~~(A) Inpatient ratio of cost-to-charges--A ratio that covers all applicable hospital costs and charges relating to inpatient care. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.~~]

[~~(B) Outpatient ratio of cost-to-charges--A ratio that covers all applicable hospital costs and charges relating to outpatient care. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.~~]

[~~(C) The terms "ratio of cost-to-charges"; "inpatient ratio of cost-to-charges"; and "outpatient ratio of cost-to-charges" are only used in the definition of "Medicaid allowable cost" as laid out in subsection (b)(11) of this section.~~]

(22) Recoupment Prevention Payment Ceiling--The maximum payment cap derived using the methodology described in subsection (c)(2) of this section that considers Medicaid only costs and payments in the methodology.

(23) [~~(19)~~] State payment cap--The maximum payment amount, as applied to interim payments that will be made for the program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The amount is calculated as described in subsection (c) [~~(1)~~] of this section using interim cost and payment data from the data year. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage or [~~;~~] costs associated with pharmacies, clinics, and physicians [~~; or costs associated with Delivery System Reform Incentive Payment projects~~].

(24) [~~(20)~~] The waiver--The Texas Healthcare Transformation and Quality Improvement Program, a Medicaid demonstration waiver under §1115 of the Social Security Act that was approved by CMS. Pertinent to this section, the waiver establishes a funding pool to assist hospitals with uncompensated-care costs.

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

(26) [~~(22)~~] Total state and local subsidies [~~payments~~]--Total [~~amount of~~] state and local subsidies is defined in §355.8065 of this division. [~~payments that a hospital received for inpatient care during the data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds, such as County Indigent Health Care, Children with Special Health Care Needs, and Kidney Health Care. The term excludes payment sources that contain federal dollars such as Medicaid payments, Children's Health Insurance Program (CHIP) payments funded under Title XXI of the Social Security Act, Substance Abuse and Mental Health Services Administration, Ryan White Title I, Ryan White Title II, Ryan White Title III, and contractual discounts and allowances related to TRICARE, Medicare, and Medicaid~~].

(27) Uncompensated Care Hospital--A hospital identified by HHSC that meets the UC program eligibility criteria to receive a payment as defined in §355.8212 of this subchapter.

(28) [~~(23)~~] Uncompensated-care waiver payments--Payments to hospitals participating in the waiver that are intended to defray the uncompensated costs of eligible services provided to eligible individuals.

(29) [~~(24)~~] Uninsured cost--The cost to a hospital of providing inpatient and outpatient hospital services to uninsured patients as defined by CMS.

(c) Calculating a state payment cap. [~~and hospital-specific limit.~~] Using information from each hospital's DSH and UC Application [~~DSH or non-DSH survey~~], Medicaid cost reports [~~report~~] and from HHSC's Medicaid contractors, HHSC will determine the hospital's state payment cap in compliance with paragraphs [~~paragraph~~] (1), (2), (3), and (4) of this subsection. The state payment cap will be used for both DSH and uncompensated care waiver interim payment determinations. [~~HHSC will determine the hospital's hospital-specific limit in compliance with paragraph (2) of this subsection.~~]

(1) Calculation of uninsured and Medicaid costs and payments. [~~State Payment Cap.~~]

(A) Uninsured charges and payments.

(i) Each hospital will report in its application [~~survey~~] its inpatient and outpatient charges for services that would be covered by Medicaid that were provided to uninsured patients discharged during the data year. In addition to the charges in the previous sentence, for DSH calculation purposes only, an IMD may report charges for Medicaid-allowable services that were provided during the data year to Medicaid-eligible and uninsured patients ages 21 through 64.

(ii) Each hospital will report in its application [~~survey~~] all payments received during the data year, regardless of when the service was provided, for services that would be covered by Medicaid and were provided to uninsured patients.

(I) For purposes of this paragraph, a payment received is any payment from an uninsured patient or from a third party (other than an insurer) on the patient's behalf, including payments received for emergency health services furnished to undocumented aliens under §1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, except as described in subclause (II) of this clause.

(II) State and local subsidies [~~payments~~] to hospitals for indigent care are not included as payments made by or on behalf of uninsured patients.

(B) Medicaid charges and payments.

(i) HHSC will request from its Medicaid contractors the inpatient and outpatient charge and payment data for claims for services provided to Medicaid-enrolled individuals that are adjudicated during the data year.

(I) The requested data will include, but is not limited to, charges and payments for:

(-a-) claims associated with the care of dually eligible patients, including Medicare charges and payments;

(-b-) claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation;

(-c-) outpatient claims associated with the Women's Health Program; and

(-d-) claims for which the hospital received payment from a third-party payor for a Medicaid-enrolled patient.

(II) HHSC will exclude charges and payments for:

(-a-) claims for services that do not meet the definition of "medical assistance" contained in §1905(a) of the Social Security Act. Examples include:

(-1-) claims for the Children's Health Insurance Program; and

(-2-) inpatient claims associated with the Women's Health Program or any successor program; and

(-b-) claims submitted after the 95-day filing deadline.

(ii) HHSC will request from its Medicaid contractors the inpatient and outpatient Medicaid cost settlement payment or recoupment amounts attributable to the cost report period determined in subparagraph (C)(i) of this paragraph.

(iii) HHSC will notify hospitals following HHSC's receipt of the requested data from the Medicaid contractors. A hospital's right to request a review of data it believes is incorrect or incomplete is addressed in subsection (e) of this section.

(iv) Each hospital will report on the application [~~survey~~] the inpatient and outpatient Medicaid days, charges and payment data for out-of-state claims adjudicated during the data year.

(v) HHSC may apply an adjustment factor to Medicaid payment data to more accurately approximate Medicaid payments, including for directed payments, following a rebasing or other change in reimbursement rates under other sections of this division.

(C) Calculation of in-state and out-of-state Medicaid and uninsured total costs for the data year.

(i) Cost report period for data used to calculate cost-per-day amounts and cost-to-charge ratios. HHSC will use information from the Medicaid cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year for the calculations described in clauses (ii)(I) and (iii)(I) of this subparagraph. For example, for program year 2013, the cost report year is the provider's fiscal year that ends between January 1, 2011, and December 31, 2011.

(I) For hospitals that do not have a full year cost report that meets this criteria, a partial year cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year will be used if the cost report covers a period greater than or equal to six months in length.

(II) The partial year cost report will not be prorated. If the provider's cost report that ends during this time period is less than six months in length, the most recent full year cost report will be used.

(ii) Determining inpatient routine costs.

(I) Medicaid inpatient cost per day for routine cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable inpatient costs by the inpatient days for each routine cost center to determine a Medicaid inpatient cost per day for each routine cost center.

(II) Inpatient routine cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the Medicaid inpatient cost per day for each routine cost center from subclause (I) of this clause times the number of inpatient days for each routine cost center from the data year to determine the inpatient routine cost for each cost center.

(III) Total inpatient routine cost. For each Medicaid payor type and the uninsured, HHSC will sum the inpatient routine costs for the various routine cost centers from subclause (II) of this clause to determine the total inpatient routine cost.

(iii) Determining inpatient and outpatient ancillary costs.

(I) Inpatient and outpatient Medicaid cost-to-charge ratio for ancillary cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable ancillary cost by the sum of the inpatient and outpatient charges for each ancillary cost center to determine a Medicaid cost-to-charge ratio for each ancillary cost center.

(II) Inpatient and outpatient ancillary cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the cost-to-charge ratio for each ancillary cost center from subclause (I) of this clause by the ancillary charges for inpatient claims and the ancillary charges for outpatient claims from the data year to determine the inpatient and outpatient ancillary cost for each cost center.

(III) Total inpatient and outpatient ancillary cost. For each Medicaid payor type and the uninsured, HHSC will sum the ancillary inpatient and outpatient costs for the various ancillary cost centers from subclause (II) of this clause to determine the total ancillary cost.

(iv) Determining total Medicaid and uninsured cost. For each Medicaid payor type and the uninsured, HHSC will sum the result of clause (ii)(III) of this subparagraph and the result of clause (iii)(III) of this subparagraph plus organ acquisition costs to determine the total cost.

~~[(D) Calculation of the state payment cap.]~~

~~*[(i)* Total hospital cost. HHSC will sum the total cost by Medicaid payor type and the uninsured from subparagraph (C)(iv) of this paragraph to determine the total hospital cost for Medicaid and the uninsured.]~~

~~*[(ii)* State payment cap.]~~

~~*[(I)* HHSC will reduce the total hospital cost under clause (i) of this subparagraph by total payments as follows:]~~

~~[(-a-) For program periods beginning on or after October 1, 2019,]~~

~~[(-b-) For program periods beginning on or after October 1, 2017, and ending on or before September 30, 2019, payments for inpatient and outpatient claims, under Title XIX of the Social Security Act, including graduate medical services and out-of-state payments, and payments on behalf of the uninsured; and]~~

~~[(-c-) For program periods beginning on or after October 1, 2013 and ending on or before September 30, 2017, from all payor sources, including graduate medical services and out-of-state payments, excluding third-party commercial insurance payors for inpatient and outpatient claims.]~~

~~*[(II)* HHSC will not reduce the total hospital cost under clause (i) of this subparagraph by supplemental payments (including upper payment limit payments), or uncompensated-care waiver payments for the data year to determine the state payment cap. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.]~~

~~[(E) Inflation adjustment.]~~

~~*[(i)* HHSC will trend each hospital's state payment cap using the inflation update factor.]~~

~~*[(ii)* HHSC will trend each hospital's state payment cap from the midpoint of the data year to the midpoint of the program year.]~~

(2) Calculation of the full-offset payment ceiling.

(A) Total hospital cost. HHSC will sum the total cost for all Medicaid payor types and the uninsured from paragraph (1)(C)(iv) of this section to determine the total hospital cost for Medicaid and the uninsured.

(B) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by total payments from all payor sources, including graduate medical services and out-of-state payments. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.

(C) Inflation adjustment. HHSC will trend each hospital's full-offset payment ceiling using the inflation update factor. HHSC will trend each hospital's state payment cap from the midpoint of the data year to the midpoint of the program year.

~~[(2) Hospital-specific limit.]~~

~~[(A) HHSC will calculate the individual components of a hospital's hospital-specific limit using the calculation set out in paragraph (1)(A) - (D)(ii)(I)(-a-) of this subsection, except that HHSC will:]~~

~~*[(i)* use information from the hospital's Medicaid cost report(s) that cover the program year and from cost settlement payment or recoupment amounts attributable to the program year for the calculations described in paragraphs (1)(C)(ii)(I) and (1)(C)(iii)(I) of this subsection. If a hospital has two or more Medicaid cost reports that cover the program year, the data from each cost report will be pro-rated based on the number of months from each cost report period that fall within the program year;]~~

~~*[(ii)* include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted from total costs as described in paragraph (1)(D)(ii)(I)(-a-) of this subsection;]~~

~~*[(iii)* use the hospital's actual charges and payments for services described in paragraph (1)(A) and (B) of this subsection provided to Medicaid-eligible and uninsured patients during the program year; and]~~

~~*[(iv)* include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.]~~

~~[(B) For payments to a hospital under the DSH program, the hospital-specific limit will be calculated at the time of the independent audit conducted under §355.8065(o) of this title.]~~

(3) Calculation of the Recoupment Prevention Payment Ceiling.

(A) Total hospital cost. HHSC will calculate total cost in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period beginning October 1, 2022, HHSC will sum the total cost from paragraph (1)(C)(iv) for the Medicaid primary payor type and the uninsured only.

(B) Total hospital payments. HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by total payments in accordance with Section 1923(g) of the Social Security Act. For example, starting with the program period beginning October 1, 2022, HHSC will reduce the total hospital cost under subparagraph (A) of this paragraph by the total payments from Medicaid and the uninsured, including graduate medical services and out-of-state payments. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the state payment cap for that program year.

(C) Inflation adjustment. HHSC will trend each hospital's recoupment prevention payment ceiling using the inflation update

factor. HHSC will trend each hospital's state payment cap from the midpoint of the data year to the midpoint of the program year.

(D) A hospital that believes that it qualifies for an exception authorized by Section 1923(g) of the Social Security Act to the calculation described in this paragraph may request that HHSC calculate the recoupment prevention payment ceiling in accordance with the exception authorized by federal law. The hospital must submit the request in accordance with subsection (f) of this section.

(4) State Payment Cap.

(A) For program periods beginning October 1, 2022, HHSC will determine the lesser of between the two payment ceilings described in paragraphs (2) and (3) of this subsection. The lesser of the two payment ceilings will constitute the State Payment Cap for the DSH program described in §355.8065 of this division and in the UC program described in §355.8212 of this subchapter.

(B) For program periods beginning on or after October 1, 2019 and ending on or before September 30, 2022, the state payment cap is described in paragraph (2) of this subsection.

(C) For program periods beginning on or after October 1, 2017 and ending on or before September 30, 2019, the state payment cap uses the costs in paragraph (2)(A) of this subsection and the payments for inpatient and outpatient claims under Title XIX of the Social Security Act, including graduate medical services and out-of-state payments, and payments on behalf of the uninsured.

(D) For program periods beginning on or after October 1, 2013 and ending on or before September 30, 2017, the state payment cap uses the costs in paragraph (2)(A) of this subsection and the payments from all payor sources, including graduate medical services and out-of-state payments, excluding third-party commercial insurance payors for inpatient and outpatient claims.

(d) Hospital-Specific Limit.

(1) HHSC will calculate the individual components of a hospital's hospital-specific limit using the calculation set out in subsection (c)(3) of this section , except that HHSC will:

(A) use information from the hospital's Medicaid cost report(s) that cover the program year and from cost settlement payment or recoupment amounts attributable to the program year for the calculations described in subsection (c)(1) of this section . If a hospital has two or more Medicaid cost reports that cover the program year, the data from each cost report will be pro-rated based on the number of months from each cost report period that fall within the program year;

(B) include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted from total costs as described in subsection (c)(3)(A) of this section;

(C) use the hospital's actual charges and payments for services described in subsection (c)(1)(A) and (c)(1)(B) of this section provided to Medicaid-eligible and uninsured patients during the program year; and

(D) include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.

(2) For payments to a hospital under the DSH program, the hospital-specific limit will be calculated at the time of the independent audit conducted under §355.8065(o) of this division.

(3) Federally authorized exceptions to the Hospital-specific limit (HSL) calculation. A hospital that believes that it qualifies for an exception authorized by Section 1923(g) of the Social Security Act to the calculation described in paragraph (f)(3) of this section may request that HHSC or its contractors calculate the HSL in accordance with the exception authorized by federal law. The following conditions and procedures will apply to all such requests received by HHSC or its contractors.

(A) The hospital must submit its request in writing to HHSC within 90 days of the end of the federal fiscal year, and the request must include any and all necessary data and justification necessary for the determination of the eligibility of the hospital to receive the exception.

(B) If HHSC approves the request, HHSC or its contractors will calculate the HSL using the methodology authorized under federal law.

(C) HHSC will notify the hospital of the results of the HSL calculation in writing.

(e) [~~(d)~~] Due date for DSH and UC Application [~~or non-DSH survey~~].

(1) HHSC Provider Finance Department [~~Rate Analysis~~] must receive a hospital's completed application [~~survey~~] no later than 30 calendar days from the date of HHSC's written request to the hospital for the completion of the application [~~survey~~], unless an extension is granted as described in paragraph (2) of this subsection.

(2) HHSC Provider Finance Department [~~Rate Analysis~~] will extend this deadline provided that HHSC receives a written request for the extension by email no later than 30 calendar days from the date of the request for the completion of the application [~~survey~~].

(3) The extension gives the requester a total of 45 calendar days from the date of the written request for completion of the application [~~survey~~].

(4) If a deadline described in paragraph (1) or (3) of this subsection is a weekend day, national holiday, or state holiday, then the deadline for submission of the completed application [~~survey~~] is the next business day.

(5) HHSC will not accept an application [~~a survey~~] or request for an extension that is not received by the stated deadline. A hospital whose application or [~~survey or~~] request for extension is not received by the stated deadline will be ineligible for DSH or uncompensated-care waiver payments for that program year.

(f) [~~(e)~~] Verification and right to request a review of data. This subsection applies to calculations under this section beginning with calculations for program year 2014.

(1) Claim adjudication. Medicaid participating hospitals are responsible for resolving disputes regarding adjudication of Medicaid claims directly with the appropriate Medicaid contractors as claims are adjudicated. The review of data described under paragraph (2) of this subsection is not the appropriate venue for resolving disputes regarding adjudication of claims.

(2) Request for review of data.

(A) HHSC will pre-populate certain fields in the DSH and UC Application [~~DSH or non-DSH survey~~], including data from its Medicaid contractors.

(i) A hospital may request that HHSC review any data in the hospital's DSH and UC Application [~~or non-DSH survey~~] that is pre-populated by HHSC.

(ii) A hospital may not request that HHSC review self-reported data included in the DSH and UC Application [~~or non-DSH survey~~] by the hospital.

(B) A hospital must submit via email a written request for review and all supporting documentation to HHSC Hospital Rate Analysis within 30 days following the distribution of the pre-populated DSH and UC Application [~~or non-DSH survey~~] to the hospital by HHSC. The request must allege the specific data omissions or errors that, if corrected, would result in a more accurate HSL.

(3) HHSC's review.

(A) HHSC will review the data that is the subject of a hospital's request. The review is:

(i) limited to the hospital's allegations that data is incomplete or incorrect;

(ii) supported by documentation submitted by the hospital or by the Medicaid contractor;

(iii) solely a data review; and

(iv) not an adversarial hearing.

(B) HHSC will notify the hospital of the results of the review.

(i) If changes to the Medicaid data are made as a result of the review process, HHSC will use the corrected data for the HSL calculations described in this section and for other purposes described in §355.8065 and §355.8212 [~~§355.8201~~] of this subchapter [~~title~~].

(ii) If no changes are made, HHSC will use the Medicaid data from the Medicaid contractors.

(C) HHSC will not consider requests for review submitted after the deadline specified in paragraph (2)(B) of this subsection.

(D) HHSC will not consider requests for review of the following calculations that rely on the Medicaid data and other information described in this subsection:

(i) the state payment cap or hospital-specific limit calculated as described in this section,[~~;~~] unless it is related to exceptions permitted by Section 1923(g) of the Social Security Act;

(ii) DSH program qualification or payment amounts calculated as described in §355.8065 of this title; or

(iii) uncompensated-care payment amounts calculated as described in §355.8201 or §355.8212 of this subchapter [~~title~~].

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 487-3480

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DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8212

STATUTORY AUTHORITY

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

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

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

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

(b) Definitions.

[~~(1) 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.~~]

(1) [~~(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).~~]

(2) [~~(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.

(3) [~~(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.

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

[~~(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.~~]

(5) [~~(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, October 1, 2011, through September 30, 2012.

(6) [~~(9)~~] Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology) [~~that serves a disproportionate share of low-income patients and is eligible for additional reimbursement from the DSH fund~~].

(7) [~~(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.

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

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

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

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

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

[~~(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).~~]

(13) [~~(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.

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

(15) [~~(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.

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

[~~(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.~~]

(17) [~~(19)~~] Rural hospital--A hospital enrolled as a Medicaid provider that:

(A) is located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or

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

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

(D) meets all of the following:

(i) has 100 or fewer beds;

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

(iii) is located in an MSA.

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

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

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

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

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

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

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

(25) [~~(22)~~] Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in [~~paragraph (5) of~~] this subsection.

(26) [~~(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.

(27) [~~(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 [~~a~~] hospital must be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year.[~~; and~~]

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

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

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

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

(F) Beginning in demonstration year thirteen, a non-rural hospital will be required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in UC.

[~~(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)~~ ~~Eligible Hospitals. 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)~~ ~~Governmental Entity Acknowledgments. 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 Provider Finance 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 Provider Finance 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 Provider Finance Department's website for each payment under this section.~~]

~~(III)~~ ~~Notification Requirement. 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) Request for Modifications. The certification forms must not be modified except for those changes approved by HHSC prior to submission.]

[(-a-) Within 10 business days of HHSC Provider Finance 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) Failure to Submit Required Documentation. 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 Provider Finance Department in writing within 30 days of the filing of bankruptcy or of changes in ownership, operation, licensure, or Medicare or Medicaid enrollment[, or affiliation] that may affect the hospital's continued eligibility for payments under this section.

(C) Merged Hospitals.

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

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

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

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

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

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

(f) Funding limitations.

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

(2) Uncompensated-care pools.

(A) HHSC will designate different pools for demonstration years as follows [establish the following uncompensated-care pools]:

(i) for demonstration years nine and ten, a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool;[. Beginning with demonstration year eleven and after, the physician group practice pool will be further divided into a state-owned physician group practice pool and a non-state-owned physician group practice pool.]

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

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

(B) [(A)] The state-owned hospital pool.

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

(C) [~~(B)~~] The state-owned physician group practice pool.

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

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

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

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

(ii) A hospital will be deemed as having a high proportion of uncompensated care charges if its impecunious charge ratio is greater than 30 percent, calculated as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(g) Uncompensated-care payment amount.

(1) Application.

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

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

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

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

(2) Calculation.

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

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

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

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

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

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

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

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

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

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

(iv) For each transferring [~~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 (relating [~~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 state payment cap for interim payments or DSH hospital-specific limit (HSL) in the UC reconciliation plus the unreimbursed costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the state payment cap or HSL for the corresponding program year.

(3) Hospital charity-care costs.

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

(B) For each hospital not required by Medicare to submit schedule S-10 of the Medicaid [~~CMS 2552-10~~] cost report, the hospital must report its hospital charity-care charges and payments in compliance with the instructions on the uncompensated-care application described in paragraph (1) of this subsection.

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

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

(4) Other eligible costs.

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

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

(ii) certain pharmacy services.

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

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

(A) A hospital:

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

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

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

(i) Such supporting documentation must include:

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

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

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

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

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

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

compensated-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, including advance payments described in paragraph (9) of this subsection, and payments allocated in preceding UC pools. For example, the HICH pool will consider UC payments allocated in the state-owned hospital and non-state-owned hospital pools.

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

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

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

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

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

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

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

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

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

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

(I) For rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all rural hospitals in the pool;

(-b-) in demonstration year:

(-1-) nine and ten, set aside for rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) eleven and after, set aside for rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount set aside for rural hospitals in demonstration year ten;

(-c-) calculate a ratio to equal the rural hospital set-aside amount from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(II) For non-rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all non-rural hospitals in the pool;

(-b-) calculate an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the set-aside amount from subclause (I)(-b-) of this clause;

(-c-) calculate a ratio to equal the result from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for non-rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each non-rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(III) The revised maximum uncompensated-care payment for the payment period equals the lesser of:

(-a-) the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph; or

(-b-) the difference between the capped payment amount from subclause (I) or (II) of this clause and the prior period payments from subparagraph (B)(i) of this paragraph.

(IV) HHSC will allocate to each non-state-owned hospital the revised maximum uncompensated-care payment amount from subclause (III) of this clause.

(7) Non-state-owned hospital SDA sub-pools. After HHSC completes the calculations described in paragraph (6) of this subsection, HHSC will place each non-state-owned hospital into a sub-pool based on the hospital's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(8) Prohibition on duplication of costs. Eligible uncompensated-care costs cannot be reported on multiple uncompensated-care applications, including uncompensated-care applications for other programs. Reporting on multiple uncompensated-care applications is a duplication of costs.

(9) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be delayed pending data submission or for other

reasons, HHSC may make advance payments to hospitals that meet the eligibility requirements described in subsection (c)(2) of this section and submitted an acceptable uncompensated-care application for the preceding demonstration year from which HHSC calculated an annual maximum uncompensated-care payment amount for that year.

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on uninsured charity-care costs reported by the hospital on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with its cost report; and

(ii) in demonstration years ten and after, be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (6)(B)(i) of this subsection.

(D) A hospital that did not submit an acceptable uncompensated-care application for the preceding demonstration year is not eligible for an advance payment.

(E) If a partial year uncompensated-care application was used to determine the preceding demonstration year's payments, data from that application may be annualized for use in the computation of an advance payment amount.

(h) Payment methodology.

(1) Notice. Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the maximum payment amount for each hospital in a pool or sub-pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for hospitals in a pool or sub-pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool or sub-pool will be determined based on the amount of funds transferred by [~~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 providers in the pool or sub-pool.

(3) Final payment opportunity. Within payments described in this section, governmental entities that do not transfer the maximum IGT amount described in paragraph (1) of this subsection during a demonstration year will be allowed to fund the remaining payments to hospitals in the pool or sub-pool at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) to the final payments up to the maximum amount; and

(B) to remaining balances for prior payment periods in the demonstration year.

(i) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period.

(1) If a hospital received payments in excess of its actual costs, the overpaid amount will be recouped from the hospital, as described in subsection (j) of this section.

(2) If a hospital received payments less than its actual costs, and if HHSC has available waiver funding for the demonstration year in which the costs were accrued, the hospital may receive reimbursement for some or all of those actual documented unreimbursed costs.

(3) Each hospital that received an uncompensated-care payment during a demonstration year must cooperate in the reconciliation process by reporting its actual costs and payments for that period on the form provided by HHSC for that purpose, even if the hospital closed or withdrew from participation in the uncompensated-care program. If a hospital fails to cooperate in the reconciliation process, HHSC may recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the governmental entities in proportion to each entity's initial contribution to funding the program for that hospital's SDA in the applicable program year.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows.

(A) HHSC will recoup from the hospital against which any overpayment was made or disallowance was directed.

(B) If the hospital has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so within 30 days of the hospital's receipt of HHSC's written notice of recoupment, HHSC may withhold any or all future Medicaid payments from the hospital until HHSC has recovered an amount equal to the amount overpaid or disallowed.

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

Filed with the Office of the Secretary of State on April 3, 2023.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: May 14, 2023
For further information, please call: (512) 487-3480

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TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 50. ALCOHOLIC BEVERAGE SELLER SERVER AND DELIVERY DRIVER TRAINING

The Texas Alcoholic Beverage Commission (TABC) proposes amendments to rules 16 TAC §§50.4, 50.15, 50.17, 50.19 - 50.20, 50.23, and 50.31, relating to Alcoholic Beverage Seller Server and Delivery Driver Training. The proposed amendments are necessary to ensure the rules accurately reflect their scope and use proper grammar. The amendment to §50.23 removes the word "Location" from the rule title because the rule does not actually address location changes for seller server schools. The remaining amendments to §§50.4, 50.15, 50.17, 50.19 - 50.20, and 50.31 simply insert or delete commas and hyphens, all of which the agency consider to be non-substantive changes. Simultaneous with this proposal, TABC is also reviewing 16 TAC §§50.1, 50.3 - 50.5, 50.8, 50.12 - 50.20, 50.23, and 50.26 - 50.33 under Texas Government Code §2001.039. That rule review is also in this edition of the *Texas Register.*

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Ashleigh Jons, Deputy Director of Training, has determined that during each year of the first five years the proposed amendments are in effect, there will be no fiscal impact on state and local governments as a result of enforcing or administering the amended rules. Ms. Jons made this determination because the proposed amendments do not add to or decrease state revenues or expenditures and because local governments are not involved in enforcing or complying with the amended rules. Ms. Jons also does not anticipate a measurable effect on local employment or a local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Ms. Jons expects that the amended rules will have the public benefit of clearly conveying the amended rules' requirements related to seller server training. Ms. Jons does not expect the proposed amendments will impose economic costs on persons required to comply with the amended rules.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TABC has determined that the proposed amendments will not have an adverse economic impact on small or micro businesses, or on rural communities. As a result, and in accordance with Texas Government Code §2006.002(c), TABC is not required to prepare a regulatory flexibility analysis.

GOVERNMENT GROWTH IMPACT STATEMENT. TABC has determined that for each year of the first five years that the proposed amendments are in effect, they:

- will not create or eliminate a government program;

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

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

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rules' applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TABC 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 Texas Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TABC will consider any written comments on the proposed amendments that are received by TABC no later than 5:00 p.m., central time, on May 14, 2023. Send your comments to rules@tabc.texas.gov or to the Office of General Counsel, Texas Alcoholic Beverage Commission, P.O. Box 13127, Austin, Texas 78711-3127. TABC staff will hold a public hearing to receive oral comments on the proposed amendments on April 27, 2023, at 10:00 a.m. THIS HEARING WILL BE HELD BY VIDEOCONFERENCE ONLY. Interested persons should visit the TABC's public website prior to the meeting date to receive further instructions or call Kelly Johnson, Legal Assistant, at (512) 206-3367.

SUBCHAPTER B. MANDATORY CURRICULUM AND COURSE OF INSTRUCTION

16 TAC §50.4

STATUTORY AUTHORITY. The amendments are proposed pursuant to TABC's rulemaking authority under §5.31 and §106.14(b) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 106.14(b) provides that TABC shall adopt rules or policies establishing the minimum requirements for approved seller training programs.

CROSS-REFERENCE TO STATUTE. The proposed amendments implement §106.14 of the Texas Alcoholic Beverage Code.

§50.4. Commission Approval of Classroom-Based Course of Instruction.

(a) (No change.)

(b) All classroom-based training materials and courses of instruction must be submitted to the commission for approval.

(1) (No change.)

(2) The 120-minute [~~120 minute~~] requirement excludes time taken for breaks and the administration of the Commission Standard Competence Test.

(3) The 120-minute [~~120 minute~~] requirement is based on a 6th grade comprehension and reading skills level.

(4) (No change.)

(c) - (d) (No change.)

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

Filed with the Office of the Secretary of State on March 28, 2023.

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James Person
General Counsel
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: May 14, 2023
For further information, please call: (512) 206-3230

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SUBCHAPTER C. ALCOHOLIC BEVERAGE SELLER SERVER AND DELIVERY DRIVER TRAINING

16 TAC §§50.15, 50.17, 50.19, 50.20, 50.23

The amendments are proposed pursuant to TABC's rulemaking authority under §5.31 and §106.14(b) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 106.14(b) provides that TABC shall adopt rules or policies establishing the minimum requirements for approved seller training programs.

§50.15. Application for Primary Classroom-Based Seller Server School Certificate.

(a) (No change.)

(b) Disclosure of Owners, Officers, Directors, Managers, and Instructors.

(1) - (5) (No change.)

(c) - (g) (No change.)

§50.17. Application for Primary Internet-Based Seller Server School Certificate.

(a) - (k) (No change.)

(l) A primary internet-based training school is required to obtain:

(1) a branch mobile application training school certificate for each delivery platform that is under common ownership with the designated primary internet-based [~~internet based~~] program. This includes, but is not limited to, programs designed for specific mobile devices or custom programming as a delivery platform for the mandatory curriculum and internet-based [~~internet based~~] testing; or

(2) (No change.)

(m) (No change.)

§50.19. Application for Primary In-House Seller Server School Certificate.

(a) - (b) (No change.)

(c) Disclosure of Owners, Officers, Directors, Managers, and Instructors.

(1) An applicant whose owners, officers, directors, and managers are an exact match to those previously provided to the commission in connection with a license or permit currently held by the applicant is exempt from the requirements of paragraphs (2), (3) and (4) of this subsection. However, the applicant must identify the license or permit application where the information requested in those paragraphs can be found.

(2) - (6) (No change.)

(d) An applicant for a primary in-house seller server school must designate:

(1) a certified trainer responsible for the oversight, operation, training, and compliance at the seller server school; and

(2) (No change.)

(e) - (g) (No change.)

§50.20. Application for Branch In-House Seller Server School Certificate.

(a) - (e) (No change.)

(f) The application for a branch classroom-based in-house seller server school certificate must designate:

(1) a certified trainer responsible for the oversight, operation, training, and compliance at the branch classroom-based in-house seller server school; and

(2) (No change.)

(g) A personal history sheet must be completed and submitted with the application for each trainer and responsible individual[~~,~~] if the individual has not previously provided a personal history sheet with the original or renewal application for the primary in-house seller server school.

(h) - (r) (No change.)

(s) The application for a branch internet-based or mobile application in-house seller server school certificate must designate:

(1) a certified trainer responsible for the oversight, operation, training, and compliance at the branch in-house seller server school; and

(2) (No change.)

(t) A personal history sheet must be completed and submitted with the application for each trainer and responsible individual[~~,~~] if the individual has not previously provided a personal history sheet with the original or renewal application for the primary in-house seller server school.

(u) - (y) (No change.)

§50.23. Change of Ownership [~~or Location~~].

(a) A change of ownership is any agreement to transfer ownership or control of a school. A change of control is presumed if:

(1) - (2) (No change.)

(3) there is a change in directors, officers, shareholders, or other governing body that results in significant changes in operations, management, or key instructors.

(b) - (f) (No change.)

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

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James Person
General Counsel
Texas Alcoholic Beverage Commission
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For further information, please call: (512) 206-3230

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SUBCHAPTER E. SELLER SERVER CERTIFICATES

16 TAC §50.31

The amendments are proposed pursuant to TABC's rulemaking authority under §5.31 and §106.14(b) of the Texas Alcoholic Beverage Code. Section 5.31 provides that TABC may prescribe and publish rules necessary to carry out the provisions of the Texas Alcoholic Beverage Code. Section 106.14(b) provides that TABC shall adopt rules or policies establishing the minimum requirements for approved seller training programs.

§50.31. Revocation.

(a) The commission may revoke a Seller Server certificate under the conditions set forth in this section.

(1) (No change.)

(2) If the holder of a Seller Server Certificate sells or serves an alcoholic beverage to a minor or intoxicated person a second time within a 12-month [~~12 month~~] period, the commission may revoke the certificate. The certificate holder cannot be recertified for a period of 90 days. Recertification requires completing a course of instruction offered by a certified school and passing the Commission Standard Competence Test.

(3) If the holder of a Seller Server Certificate sells or serves an alcoholic beverage to a minor or intoxicated person a third time within a 12-month [~~12 month~~] period, the commission may revoke the certificate. The certificate holder cannot be recertified for a period of one year. Recertification requires completing a course of instruction offered by a certified school and passing the Commission Standard Competence Test.

(4) - (5) (No change.)

(b) (No change.)

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

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James Person
General Counsel
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PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 115. MIDWIVES

The Texas Department of Licensing and Regulation (Department) proposes amendments to existing rules at 16 Texas Administrative Code (TAC) at Chapter 115, §§115.1, 115.4, 115.5, 115.13 - 115.15, 115.20, 115.21, 115.23, 115.25, 115.70, 115.80, 115.100, and 115.120, the repeal of §§115.2, 115.16 and 115.121 and new rules §§115.2, 115.12, 115.16, 115.22, and 115.121; regarding the Midwives program. These proposed changes are referred to as "proposed rules."

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC Chapter 115 implement Texas Occupations Code, Chapter 203, Midwives.

The proposed rules implement changes recommended by Department staff as a result of the four-year rule review conducted under Texas Government Code §2001.039. The proposed rules update requirements relating to approval of basic midwifery education courses, preceptor supervision of student clinical experience, informed client choice and disclosure statements, and retired midwife licenses. The proposed rules also make updates to reflect current Department procedures and remove obsolete or unnecessary language.

The Notice of Intent to Review for Chapter 115 was published in the October 9, 2020, issue of the *Texas Register* (45 TexReg 7281). The public comment period closed on November 9, 2020. At its meeting on March 3, 2021, the Texas Commission of Licensing and Regulation (Commission) readopted Chapter 115 in its entirety without changes. The readoption notice was published in the March 26, 2021, issue of the *Texas Register* (46 TexReg 2050). In response to the Notice of Intent to Review for Chapter 115 that was published, the Department received comments from one interested party requesting rule changes that would not be possible without statutory changes. Therefore, the proposed rules do not include any changes in response to public comments, and all the changes are based on recommendations by Department staff.

The proposed rules were presented to and discussed by the Midwives Advisory Board at its meeting on March 29, 2023. The Advisory Board made a change to proposed §115.13(a)(3)(B) by adding "and passing" to clarify that the course and exam must be passed. The Advisory Board voted and recommended that the proposed rules with changes be published in the *Texas Register* for public comment.

SECTION-BY-SECTION SUMMARY

The proposed rules amend §115.1, Definitions, by changing the term "approved midwifery education courses" to "basic midwifery education course" and updating its definition to provide clarity and consistency with Occupations Code §203.151; removing the definition for "Code" because the term is not used elsewhere in the rule chapter; adding a definition for "compensation" to provide clarity; adding a definition for "CPR certification" to streamline multiple references throughout the chapter; adding a definition for "direct supervision" to provide clarity; adding a definition for the acronym "MANA" to streamline multiple references to the Midwives Alliance of North America; adding a definition for the acronym "MEAC" to streamline multiple references to the Midwifery Education Accreditation Council; adding a definition for the acronym "NARM" to streamline multiple references to the North American Registry of Midwives; adding a definition for "preceptor" to provide clarity; removing the definition of "Program" because the term is not used elsewhere in the rule chapter; updating the definition of "retired midwife" to provide clarity and remove the age requirement; correcting a rule reference in the definition of "standing delegation orders"; adding a definition for "student" to provide clarity; and renumbering the remaining definitions accordingly.

The proposed rules repeal current §115.2 and replace it with new §115.2, License Required, to prohibit the unlicensed practice of midwifery.

The proposed rules amend §115.4, Advisory Board Membership, by amending paragraph (1) to provide consistency with Occupations Code §203.052.

The proposed rules amend §115.5, "Terms; Vacancies", by amending subsections (a) and (b) to provide consistency with Occupations Code §203.055.

The proposed rules add new §115.12, General Application Requirements, to streamline requirements for all applications submitted to the Department; add new subsection (a) consisting of language relocated from current §115.13(a) and (a)(1); and add new subsection (b) to require that original or certified copies of documents must be provided upon request by the Department.

The proposed rules amend §115.13, Initial Application for Licensure, by relocating language from subsections (a) and (a)(1) to proposed new §115.12(a); removing subsections (a)(1)(A) through (a)(1)(E), which consist of application details that can instead be addressed in the application forms approved by the Department; updating subsection (a)(2) to provide clarity and correct grammar; relocating and reorganizing the language in current subsection (a)(2) to become new subsection (a)(3); relabeling current subsection (a)(3) to become new subsection (a)(4) and removing the language that repeats the proposed new definition for "CPR certification" in §115.1; relabeling current subsection (a)(4) to become new subsection (a)(5) and adding language to allow the Department to approve a certification that is equivalent to the certification in neonatal resuscitation from the American Academy of Pediatrics; relabeling current subsection (a)(5) to become new subsection (a)(6) and reorganizing its language for clarity; relabeling current subsection (a)(6) to become new subsection (a)(7) and removing unnecessary language; relabeling current subsection (a)(7) to become new subsection (a)(8) and rephrasing its language for clarity and consistency; rephrasing subsection (b) for clarity and consistency; and creating new subsection (f) consisting of language relocated from current §115.2(b). The Advisory Board made a change to subsection (a)(3)(B) by adding "and passing" to clarify that the course and exam must be passed.

The proposed rules amend §115.14, License Renewal, by adding to subsection (a) the word "midwife" to clarify the section's applicability to renewal of a midwife license; removing from subsection (a)(3) language that repeats the proposed new definition for "CPR certification" in §115.1; and adding new subsection (e) to provide that each applicant for renewal of a midwife license must successfully pass a criminal history background check.

The proposed rules amend §115.15, Late Renewal, by rephrasing for clarity and adding references to other Department rules applicable to late renewals.

The proposed rules repeal current §115.16 and replace it with new §115.16, Retired Voluntary Charity Care Status License, consisting of subsection (a) to explain the applicability of the section; subsection (b) to provide the eligibility requirements for a retired voluntary charity care status license; subsection (c) to provide the requirements for an initial application for a voluntary charity care status license; subsection (d) to provide the limitations on the practice of a person holding a retired voluntary charity care status license; subsection (e) to detail the actions for which a person holding a retired voluntary charity care status license will be subject to disciplinary action; subsection (f) to provide for the two-year license term of a retired voluntary charity care status license; subsection (g) to provide the renewal application requirements, the procedures for late renewal, and the prohibition on unlicensed activity for a voluntary charity care status license; and subsection (h) to provide the requirements for a person who holds a retired voluntary charity care status license and wants to return to active status.

The proposed rules amend §115.20, Basic Midwifery Education, by amending the section title for clarity; rephrasing and restructuring the rule language to remove the need for subsection labels; relocating from current subsection (a) to new paragraph (1) the requirement for a course to have a course administrator and site in Texas; relabeling current subsection (b)(2) to become new paragraph (2) and rephrasing its language for clarity; relabeling current subsection (b)(3) to become new paragraph (3) and replacing the names of entities with their corresponding acronyms defined in §115.1; relabeling current subsection (b)(4) to become new paragraph (4) and rephrasing its language for clarity; relabeling current subsection (b)(5) to become new paragraph (5) and rephrasing its language for clarity; relabeling current subsection (b)(6) to become new paragraph (6) and amending its language to provide consistency with the clinical experience requirements for certification by the North American Registry of Midwives (NARM); relabeling current subsection (b)(7) to become new paragraph (7) and removing unnecessary language that repeats the new definition for "preceptor" in §115.1; relabeling current subsection (c) to become new paragraph (8), rephrasing its language for clarity, and removing the language that repeats the new definition for "CPR certification" in §115.1.

The proposed rules amend §115.21, Education Course Approval, by amending the section title for clarity and consistency; rephrasing subsection (a)(1) for clarity and consistency; modifying subsection (a)(1)(D) to require that the financial statement or balance sheet must demonstrate the ability to provide refunds to any students who enroll and removing the requirement to disclose any bankruptcy within the last five years; in subsection (a)(1)(E), adding the requirement for written policies to include entrance requirements, a list of all fees, and the notice required by Occupations Code §53.152 and removing requirements for language and accessibility covered by other state and federal laws; in subsection (a)(2), changing the time period for retention of student files from five years to "three years after the student is no longer enrolled in the course" to provide a more definite time period, clarifying that student files must include CPR certification and progression of course work; amending subsection (a)(3) to clarify the process for initial course approval; rephrasing subsections (a)(4) through (a)(6) for clarity; amending subsection (b) to clarify the approval of courses accredited by MEAC; amending subsection (c) to clarify the duration of course approval and the process for obtaining a new approval period; amending subsection (d) to require a substantive change in a course to be approved before the change is implemented; and adding new subsection (e) to allow courses to accept transfer hours from other courses and clinical hours earned under a NARM-certified preceptor.

The proposed rules add new §115.22, Preceptor Supervisory Responsibilities, consisting of new subsection (a) to provide the requirements relating to clinical experience activities performed by a student, including direct supervision by a preceptor and informed consent by the client; new subsection (b) to clarify that the student is not practicing midwifery; and new subsection (c) to provide that a licensed midwife acting as a preceptor is responsible for the actions of the student.

The proposed rules amend §115.23, Jurisprudence Examination, by adding new subsection (d) to address administration of the examination, examination fees, reexamination, and no-

tice of examination results, as required by Occupations Code §203.2555(b).

The proposed rules amend §115.25, Continuing Education, by rephrasing and reorganizing for clarity and removing accessibility requirements covered by other state and federal laws.

The proposed rules amend §115.70, Standards of Conduct, by removing the language in current paragraph (1)(L), which authorizes administrative action due to "a lack of personal or professional character in the practice of midwifery" because the standard is vague and subjective; renumbering the remaining provisions in paragraph (1) accordingly; and updating paragraph (3) to clarify that course approval may be suspended or revoked, add loss of MEAC accreditation as a reason for course suspension or revocation, and make cleanup changes for clarity.

The proposed rules amend §115.80, Fees, by updating the names of fees for clarity and consistency and reducing the retired voluntary charity care status license fees in paragraphs (4) and (5) from $275 to $0.

The proposed rules amend §115.100, Standards for the Practice of Midwifery in Texas, by making cleanup changes to subsections (a) and (c) for clarity and consistency.

The proposed rules amend §115.120, Newborn Screening, to clarify the requirements relating to a midwife who chooses to collect blood specimens for newborn screening tests, including the required training and submission of the appropriate form to the Department, and removing unnecessary language.

The proposed rules repeal current §115.121 and replace with new §115.121, Informed Choice and Disclosure Statement, by removing unnecessary language that merely repeats Occupations Code §203.351; adding new subsection (a) to require a midwife to use the form prescribed by the Department; adding new subsection (b) to require a midwife to provide the content of the form to a prospective client in both oral and written form before providing any midwifery service; and adding new subsection (c) to require a student performing clinical experience activities to first obtain the informed consent required by proposed new §115.22.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Tony Couvillon, Policy Research and Budget Analyst, has determined that for each year of the first five years the proposed rules are in effect, enforcing or administering the proposed rules does not have foreseeable implications relating to costs or revenues of state or local governments.

LOCAL EMPLOYMENT IMPACT STATEMENT

Mr. Couvillon has determined that the proposed rules will not affect the local economy, so the agency is not required to prepare a local employment impact statement under Government Code §2001.022.

PUBLIC BENEFITS

Mr. Couvillon has determined that for each year of the first five-year period the proposed rules are in effect, the public benefit will be providing the rules with increased clarity and organization to ensure midwives meet the minimum licensing requirements to obtain or renew their licenses; allowing additional paths of reciprocity by allowing the transfer of hours from an out-of-state school or preceptor; and the outlining of the preceptor supervisory responsibilities.

PROBABLE ECONOMIC COSTS TO PERSONS REQUIRED TO COMPLY WITH PROPOSAL

Mr. Couvillon has determined that for each year of the first five-year period the proposed rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules.

FISCAL IMPACT ON SMALL BUSINESSES, MICRO-BUSINESSES, AND RURAL COMMUNITIES

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

ONE-FOR-ONE REQUIREMENT FOR RULES WITH A FISCAL IMPACT

The proposed rules do not have a fiscal note that imposes a cost on regulated persons, including another state agency, a special district, or a local government. Therefore, the agency is not required to take any further action under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Government Code §2001.0221, the agency provides the following Government Growth Impact Statement for the proposed rules. For each year of the first five years the proposed rules will be in effect, the agency has determined the following:

1. The proposed rules do not create or eliminate a government program.

2. Implementation of the proposed rules does not require the creation of new employee positions or the elimination of existing employee positions.

3. Implementation of the proposed rules does not require an increase or decrease in future legislative appropriations to the agency.

4. The proposed rules do require an increase or decrease in fees paid to the agency. The proposed rules eliminate the license renewal and reinstatement fees for retired midwives performing voluntary charity care.

5. The proposed rules do not create a new regulation.

6. The proposed rules do expand, limit, or repeal an existing regulation. The proposed rules expand certain rules to clarify requirements relating to preceptor supervisory responsibilities, applications for retired voluntary charity care status licenses, and the submission of original or certified copies of documents, when required.

7. The proposed rules do not increase or decrease the number of individuals subject to the rules' applicability.

8. The proposed rules do not positively or adversely affect this state's economy.

TAKINGS IMPACT ASSESSMENT

The Department has determined that no private real property interests are affected by the proposed rules and the proposed rules do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the

absence of government action. As a result, the proposed rules do not constitute a taking or require a takings impact assessment under Government Code §2007.043.

PUBLIC COMMENTS

Comments on the proposed rules may be submitted electronically on the Department's website at *https://ga.tdlr.texas.gov:1443/form/gcerules;* by facsimile to (512) 475-3032; or by mail to Shamica Mason, Legal Assistant, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711. The deadline for comments is 30 days after publication in the *Texas Register.*

16 TAC §§115.1, 115.2, 115.4, 115.5, 115.12 - 115.16, 115.20 - 115.23, 115.25, 115.70, 115.80, 115.100, 115.120, 115.121

STATUTORY AUTHORITY

The proposed rules are proposed under Texas Occupations Code, Chapters 51 and 203, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The proposed rules are also proposed under Texas Government Code, Chapter 411, Subchapter F, and Texas Occupations Code, Chapters 51 and 53, which establish the Department's statutory authority to conduct criminal history background checks on an applicant for or a holder of a license, certificate, registration, title, or permit issued by the Department. The proposed rules are also proposed under Texas Occupations Code, Chapter 112, which requires the adoption of rules providing for reduced fees and continuing education requirements for a retired health care practitioner whose only practice is voluntary charity care.

The statutory provisions affected by the proposed rules are those set forth in Texas Occupations Code, Chapters 51 and 203, and Texas Government Code, Chapter 411, Subchapter F. No other statutes, articles, or codes are affected by the proposed rules.

§115.1. Definitions.

The following words and terms when used in this chapter [~~shall~~] have the following meaning unless the context clearly indicates otherwise.

(1) - (3) (No change.)

(4) Basic [~~Approved~~] midwifery education course [~~courses~~]--A course [~~The basic midwifery education courses~~] approved by the department to fulfill the education requirement for obtaining an initial midwife license.

[~~(5) Code--Texas Health and Safety Code.~~]

(5) [~~(6)~~] Collaboration--The process in which a midwife and a physician or another licensed health care professional of a different profession jointly manage the care of a woman or newborn according to a mutually agreed-upon plan of care.

(6) [~~(7)~~] Commission--The Texas Commission of Licensing and Regulation.

(7) Compensation--Direct or indirect payment of anything of monetary value, except payment or reimbursement of reasonable, necessary, and actual travel and related expenses.

(8) (No change.)

(9) CPR certification--Official documentation of successful completion of a course in cardiopulmonary resuscitation issued by:

(A) the American Heart Association, for health care providers;

(B) the Red Cross, for the professional rescuer;

(C) the National Safety Council, for healthcare providers and the professional rescuer; or

(D) any other provider of a CPR course for health care providers currently accepted by the Department of State Health Services' Office of EMS/Trauma Systems Coordination.

(10) [~~(9)~~] Department--The Texas Department of Licensing and Regulation.

(11) Direct supervision--Real-time, in-person observation and guidance by a preceptor who is physically present and immediately available to provide any necessary assistance and personally respond to any emergency.

(12) [~~(10)~~] Executive director--The executive director of the department.

(13) [~~(11)~~] Health authority--A physician who administers state and local laws regulating public health under the Health and Safety Code, Chapter 121, Subchapter B.

(14) [~~(12)~~] Local health unit--A division of a municipality or county government that provides limited public health services as provided by the Health and Safety Code, §121.004.

(15) MANA--The Midwives Alliance of North America.

(16) MEAC--The Midwifery Education Accreditation Council.

(17) NARM--The North American Registry of Midwives.

(18) [~~(13)~~] Newborn care--The care of a child for the first six weeks of the child's life.

(19) [~~(14)~~] Normal childbirth--The labor and vaginal delivery at or close to term (37 up to 42 weeks) of a pregnant woman whose assessment reveals no abnormality or signs or symptoms of complications.

(20) [~~(15)~~] Physician--A physician licensed to practice medicine in Texas by the Texas Medical Board.

(21) [~~(16)~~] Postpartum care--The care of a woman for the first six weeks after the woman has given birth.

(22) Preceptor--an individual who provides direct supervision of a student and is:

(A) a midwife licensed in Texas;

(B) a certified nurse-midwife, as defined in the Act; or

(C) a physician licensed in Texas and actively engaged in the practice of obstetrics in an out-of-hospital setting.

[~~(17) Program--The department's midwifery program.~~]

(23) [~~(18)~~] Public health district--A district created under the Health and Safety Code, Chapter 121, Subchapter E.

(24) [~~(19)~~] Referral--The process by which a midwife directs the client to a physician or another licensed health care professional who has current obstetric or pediatric knowledge and who is working under supervision and delegation of a physician.

(25) [~~(20)~~] Retired midwife--A person holding a retired voluntary charity care status license under §115.16. [~~midwife licensed in Texas who is over the age of 55 and not currently employed in a health care field.~~]

(26) [~~(21)~~] Standing delegation orders--Written instructions, orders, rules, regulations or procedures prepared by a physician and designated for a patient population, and delineating under what set of conditions and circumstances actions should be instituted, as described in the rules of the Texas Medical Board in 22 Texas Administrative Code, Chapter 193 (relating to Standing Delegation Orders) [~~and §115.111 of this title (relating to Coordinating Care with Other Health Care Providers)~~].

(27) Student--A person performing activities under a basic midwifery education course or a preceptorship to fulfill the requirements for a midwife license or certification by NARM.

(28) [~~(22)~~] Transfer--The process by which a midwife relinquishes care of the client for pregnancy, labor, delivery, or postpartum care or care of the newborn to a physician or another licensed health care professional who has current obstetric or pediatric knowledge and who is working under the supervision and delegation of a physician.

(29) [~~(23)~~] Voluntary charity care--Midwifery care provided without compensation and with no expectation of compensation.

§115.2. License Required.

A person may not practice midwifery unless the person holds a license issued under the Act.

§115.4. Advisory Board Membership.

The Midwives Advisory Board consists of nine members appointed by the presiding officer of the commission, with the approval of the commission as follows:

(1) five licensed midwife members each of whom has at least three years' experience in the practice of midwifery;

(2) - (4) (No change.)

§115.5. Terms; Vacancies.

(a) Members of the advisory board serve staggered six-year terms. The terms of three members expire [~~expiring~~] on January 31st of each odd-numbered year.

(b) If a vacancy occurs on the board during a member's term, the presiding officer of the commission, with the commission's approval, must [~~shall~~] appoint a replacement who meets the qualifications for the vacant position to serve for the remainder of the term.

(c) (No change.)

§115.12. General Application Requirements.

(a) Unless otherwise indicated, all applications, required information, and documentation of credentials must be submitted on department-approved forms and in the manner prescribed by the department.

(b) Applicants must submit original or certified copies of documents if requested by the department.

§115.13. Initial Application for Licensure.

(a) Initial licensure. [~~Unless otherwise indicated, an applicant must submit all required information and documentation of credentials on official department-approved forms.~~] An individual may apply for licensure as a midwife at any time during the year by submitting the following to the department:

(1) a completed application; [~~on a department-approved form which shall contain:~~]

[~~(A) specific information regarding personal data, social security number, birth date, other licenses held, and misdemeanor or felony convictions;~~]

[~~(B) the date of the application;~~]

[~~(C) a statement that the applicant has read the Act and these rules and agrees to abide by them;~~]

[~~(D) a statement that the information in the application is truthful and that the applicant understands that providing false and misleading information on items which are material in determining the applicant's qualifications may result in the voiding of the application, or denial or the revocation of any license issued; and~~]

[~~(E) any other information required by the department.~~]

(2) proof of successful [~~satisfactory~~] completion of a continuing education course covering the current Texas Midwifery Basic Information and Instructor [~~Instructors~~] Manual;[~~, and:~~]

[~~(A) satisfactory completion of a mandatory basic midwifery education course approved by the department and the North American Registry of Midwives (NARM) exam or any other comprehensive exam approved by the department;~~]

[~~(B) Certified Professional Midwife (CPM) certification by NARM; or~~]

[~~(C) satisfactory completion of a basic midwifery education course accredited by the Midwifery Education Accreditation Council (MEAC), and the North American Registry of Midwives (NARM) exam, or any other comprehensive exam approved by the department.~~]

(3) proof of one of the following:

(A) Certified Professional Midwife certification by NARM; or

(B) successful completion and passing of:

(i) a basic midwifery education course; and

(ii) the NARM exam or any other comprehensive exam approved by the department;

(4) [~~(3)~~] proof of current CPR [~~cardiopulmonary resuscitation (CPR)~~] certification; [~~for health care providers by the American Heart Association; equivalent certification for the professional rescuer from the Red Cross; equivalent certification for healthcare and professional rescuer from the National Safety Council; or equivalent certification issued by any provider of CPR certification for health care providers currently accepted by the Department of State Health Service's Office of EMS/Trauma Systems Coordination;~~]

(5) [~~(4)~~] proof of current certification in [~~for~~] neonatal resuscitation, §§1 - 4, from the American Academy of Pediatrics or an equivalent certification approved by the department;

(6) [~~(5)~~] proof of one of the following:

(A) satisfactory completion of training in the collection of newborn screening specimens; or

(B) an established relationship with another qualified and appropriately credentialed health care provider who has agreed to collect newborn screening specimens on behalf of the applicant;

(7) [~~(6)~~] the [~~a nonrefundable~~] fee required under §115.80; and

(8) [~~(7)~~] proof of passing the jurisprudence examination approved by the department within[~~. The jurisprudence examination must have been taken no more than~~] one year prior to the date of application.

(b) Initial licensure after interim of more than four years. An application for [~~A midwife seeking~~] initial licensure submitted more than [~~who has not become licensed within~~] four years after the applicant's completion of [~~completing~~] a basic midwifery education course [~~approved by the department or accredited by MEAC shall in addition~~] must also include [~~provide~~] proof of completion of [~~having completed~~] at least 40 [~~contact~~] hours of [~~approved midwifery~~] continuing education within the year preceding the application, which must include [~~shall be based upon~~] a review of:

(1) the current Texas Midwifery Basic Information and Instructor [~~Instructors~~] Manual; and

(2) the current MANA [~~Midwives Alliance of North America (MANA)~~] Core Competencies and Standards of Practice.

(c) - (e) (No change.)

(f) An initial midwife license is valid from the date of issuance until March 1 of the second calendar year following the calendar year in which it is issued.

§115.14. License Renewal.

(a) A midwife license may be renewed for a two-year period by submitting to the department:

(1) - (2) (No change.)

(3) proof of [a] current CPR certification; [~~for health care providers from one of the following:~~]

[~~(A) the American Heart Association;~~]

[~~(B) equivalent certification for the professional rescuer from the Red Cross;~~]

[~~(C) equivalent certification for healthcare and professional rescuer from the National Safety Council; or~~]

[~~(D) equivalent certification issued by any provider of CPR certification for health care providers currently accepted by the Department of State Health Services' Office of EMS/Trauma Systems Coordination;~~]

(4) - (7) (No change.)

(b) - (d) (No change.)

(e) An individual applying for renewal of a midwife license must successfully pass a criminal history background check.

§115.15. Late Renewal.

Late license renewal. A midwife whose license has expired [~~who fails to apply for license renewal by March 1 of the end of a renewal period in which the midwife is currently licensed,~~] may apply for late license renewal in accordance with the department's procedural rules at 16 TAC §60.31 and §60.83 [~~on or before March 1 of the following year~~]. Applications for late license renewal must include the following:

(1) each of the items required for timely renewal; and

(2) the [~~a nonrefundable late renewal~~] fee required under §115.80.

§115.16. Retired Voluntary Charity Care Status License.

(a) Applicability. This section implements Texas Occupations Code, Chapter 112. This section applies to a person who holds a midwife license issued by the department.

(b) Eligibility. To be eligible for a retired voluntary charity care status license, the person must:

(1) hold an active midwife license issued by the department;

(2) not have any pending or current disciplinary actions against the person or the person's license; and

(3) not be employed, under contract, or otherwise engaged in the practice of midwifery for compensation.

(c) Initial application. To apply for a retired voluntary charity care status license, the person must:

(1) submit a completed application on a department-approved form;

(2) certify in writing that the person is retired and will provide only voluntary charity care;

(3) submit any fee required under §115.80; and

(4) successfully pass a criminal history background check.

(d) Practice. A person holding a retired voluntary charity care status license:

(1) may not provide midwifery services for compensation; and

(2) is limited to providing only those services authorized under a midwife license.

(e) Disciplinary actions. A person holding a retired voluntary charity care status license is subject to disciplinary action for:

(1) a violation of the Act or the rules adopted under this chapter;

(2) obtaining, or attempting to obtain, retired voluntary charity care status by submitting false or misleading information to the department; or

(3) engaging in the practice of midwifery for compensation.

(f) License term. A retired voluntary charity care status license is valid for two years from the date of issuance and may be renewed biennially.

(g) Renewal.

(1) To renew a retired voluntary charity care status license, a licensee must:

(A) submit a completed application on a department-approved form;

(B) submit all the items required for renewal of a midwife license under §115.14, with the exception that only five hours of continuing education must be completed;

(C) submit any fee required under §115.80; and

(D) successfully pass a criminal history background check.

(2) A person whose retired voluntary charity care status license has expired may late renew the license in accordance with the department's procedural rules at 16 TAC §60.31 and §60.83.

(3) A person whose retired voluntary charity care status license has expired may not practice or engage in midwifery or perform voluntary charity care.

(h) Returning to active status.

(1) A person who holds a retired voluntary charity care status license and who wants to return to active status must:

(A) submit a completed application on a department-approved form;

(B) complete 10 hours of continuing education in the 12 months preceding the application;

(C) submit the midwife license renewal application fee required under §115.80; and

(D) successfully pass a criminal history background check.

(2) The application must be approved by the department before the person can return to active status and provide midwifery services for compensation.

§115.20. Basic Midwifery Education Course Eligibility.

[~~(a)~~] To be eligible for approval by the [~~The~~] department as a basic midwifery education course, a course must: [~~shall consider for approval only courses which have a course supervisor/administrator and site in Texas.~~]

[~~(b)~~] [~~Mandatory basic midwifery education shall:~~]

(1) have a course administrator and site in Texas [~~be offered to ensure that only trained individuals practice midwifery in Texas~~];

(2) be offered only by an [~~any~~] individual or organization meeting the requirements for course approval established by this section [~~subsection~~];

(3) include a didactic component which must [~~shall~~]:

(A) be based upon and completely cover the [~~most~~] current Core Competencies and Standards of Practice of MANA [~~the Midwives Alliance of North America (MANA)~~] and the current Texas Midwifery Basic Information Manual;

(B) prepare the student to apply for certification by NARM; [~~North American Registry of Midwives (NARM);~~] and

(C) include a minimum of 250 hours course work.

(4) be supervised and conducted by a course administrator [~~supervisor/administrator~~] who must [~~shall~~]:

(A) be responsible for all aspects of the course; [~~and~~]

(B) have two years of experience in the independent practice of midwifery, nurse-midwifery, or obstetrics; [~~and~~]

(C) have been primary care giver for at least 75 births including provision of prenatal, intrapartum, and postpartum care; and

(D) be at least one of the following: [~~have met initial licensure requirements; or~~]

(i) a licensed midwife;

(ii) [~~(E)~~] [~~be~~] a Certified Professional Midwife (CPM); [~~or~~]

(iii) [~~(F)~~] [~~be~~] American College of Nurse Midwives (ACNM) certified; or

(iv) [~~(G)~~] [~~be~~] a [~~licensed~~] physician licensed in Texas and actively engaged in the practice of obstetrics;[~~.~~]

(5) include didactic curriculum instructors who:

(A) have training and credentials for the course material they will teach; and

(B) are approved by the course administrator [~~supervisor/administrator~~].

(6) provide clinical experience [~~experience/preceptorship~~] of at least two years [~~one year~~] but no more than five years and equivalent to 1,350 clinical contact hours which prepares the student to become certified by NARM, including successful completion of at least the following activities:

(A) Phase 1. Document attendance at 10 births in any setting, in any capacity (observer, doula, family member, friend, beginning student).

(i) The births may be verified by any witness who was present at the birth.

(ii) The births may not include the person's own birth.

(B) Phase 2. Document completion of the following activities, as an assistant under direct supervision:

(i) 20 births;

(ii) 25 prenatal exams, including 3 initial exams;

(iii) 20 newborn exams; and

(iv) 10 postpartum exams.

(C) Phase 3. Document completion of the following activities, as a primary under direct supervision:

(i) 20 births, including:

(I) five births for which the student provides a continuity of care consisting of a minimum of:

(-a-) five prenatal exams spanning at least two trimesters;

(-b-) the birth, including the placenta;

(-c-) the newborn exam (within 12 hours of the birth); and

(-d-) at least two postpartum exams (between 24 hours and 6 weeks following the birth); and

(II) 10 births that include at least one prenatal exam;

(ii) 75 prenatal exams, including 20 initial exams;

(iii) 20 newborn exams; and

(iv) 40 postpartum exams;

[~~(A) serving as an active participant in attending 20 births;~~]

[~~(B) serving as the primary midwife, under supervision, in attending 20 additional births, at least 10 of which shall be out-of-hospital births. A minimum of 3 of the 20 births attended as primary midwife under supervision must be with women for whom the student has provided primary care during at least 4 prenatal visits, birth, newborn exam and one postpartum exam;~~]

[~~(C) serving as the primary midwife, under supervision, in performing:~~]

[~~(i)~~ ~~75 prenatal exams, including at least 20 initial history and physical exams;~~]

[~~(ii)~~ ~~20 newborn exams; and~~]

[~~(iii)~~ ~~40 postpartum exams.~~]

(7) include preceptors who are approved by the course administrator; [~~supervisor/administrator and shall be:~~]

[~~(A) licensed midwives;~~]

[(B) certified professional midwives;]

[(C) certified nurse midwives; or]

[(D) physicians licensed in the United States and actively engaged in the practice of obstetrics.]

(8) [(c)] allow student enrollment only to individuals who [Individuals enrolled as students in an approved midwifery course must] possess:

(A) [(i)] a high school diploma or the equivalent; and

(B) [(2)] [a] current CPR certification [Cardiopulmonary Resuscitation (CPR) certificate for health care providers from the American Heart Association; an equivalent CPR certificate for the professional rescuer from the Red Cross; equivalent certification for healthcare and professional rescuer from the National Safety Council; or equivalent certification issued by any provider of CPR certification for health care providers currently accepted by the Department of State Health Services' Office of EMS/Trauma Systems Coordination].

§115.21. Basic Midwifery Education Course Approval.

(a) Course approval.

(1) To obtain initial approval as a basic midwifery education course, the [The] course administrator must [supervisor/administrator shall] submit to the department a completed [an] application, the [form and a non-refundable initial midwifery course application] fee required under §115.80, and [to the department with] the following supporting documentation:

(A) course outline;

(B) course curriculum with specific content references to:

(i) MANA Core Competencies;

(ii) NARM Written Test Specifications;

(iii) NARM Skills Assessment Test Specifications;

(iv) Texas Midwifery Basic Information and Instructor Manual; and

(v) protocol writing, adaptation, and revision;[.]

(C) identification of didactic and preceptorship teaching sites;

(D) a financial statement or balance sheet (within the last year) for the course administrator [supervisor/administrator] or course owner demonstrating the ability to provide refunds to any students who enroll [and disclosure of any bankruptcy within the last five years]; and

(E) written policies to include:

(i) entrance requirements;

(ii) [(i)] a tuition schedule and a list of all additional fees or[, other] charges;[, and]

(iii) cancellation and refund policy, including the right of any prospective student to cancel an [his/her] enrollment agreement within 72 hours after signing the agreement and receive a full refund of any money paid;

(iv) [(ii)] student attendance, progress, and grievance policies;

(v) [(iii)] rules of operation and conduct of course [school] personnel;

(vi) [(iv)] information on the requirements for state licensure, including the notice required by Occupations Code §53.152;

(vii) [(v)] disclosure of the approval status of the course; and

(viii) [(vi)] maintenance of student files.[; and]

[(vii) reasonable access for non-English speakers and compliance with federal and state laws on accessibility.]

(2) Student files must [shall] be maintained for a minimum of three [five] years after the student is no longer enrolled in the course and must [shall] include:

(A) evidence that the entrance requirements have been met, including CPR certification;

(B) documentation of progression and [demonstrating] completion of didactic and clinical course work; and

(C) copies of any financial agreements between the student and the course [school].

(3) [The department staff shall review each course application submitted for approval.] If an application for initial approval meets all [of] the requirements [specified in this paragraph], a one-year provisional approval will be granted. The course administrator must then schedule with the department an [An] on-site evaluation of the course to occur within the provisional year [shall be scheduled]. The evaluation must [shall] be conducted by [a member of the] department staff and a licensed midwife within the provisional year. If the department is unable to conduct an on-site evaluation within the provisional year, the provisional approval will be extended until the department conducts an on-site evaluation and issues its approval or denial of the course. The on-site evaluation [site visit] will include the following:

(A) an inspection of the course's facilities;

(B) a review of its teaching plan, protocols, and teaching materials;

(C) a review of didactic and preceptorship instruction;

(D) interviews with staff and students; and

(E) a review of student, staff and preceptor files, to include coursework, protocols, and financial records.

(4) The [A nonrefundable site visit] fee required under §115.80 will [shall] be assessed for each on-site evaluation [site visit].

(5) The on-site evaluation [site visit] written report will [shall] recommend to the department approval or denial of the course.

(6) The department will [shall] evaluate the application and all other pertinent information, including any complaints received and the on-site evaluation [site visit] report.

(b) Course reciprocity. A [basic midwifery education] course located in Texas which is currently accredited or pre-accredited by MEAC will [the Midwifery Education Accreditation Council (MEAC) shall] be deemed approved as a basic midwifery education course, without an on-site evaluation, under this subsection upon submission to the department of evidence of such accreditation and the fee required under §115.80. An approval under this subsection is effective only for the period of time during which the course is accredited or pre-accredited by MEAC. A course approved under this subsection that later has its MEAC accreditation or pre-accreditation suspended or revoked must apply for department approval under subsection (a) within 10 days after the suspension or revocation.

(c) Duration of course approval.

(1) The department will [~~shall~~] approve basic midwifery education courses for a three year period. A course with reciprocity under subsection (b) will continue its reciprocity for as long as the course maintains MEAC accreditation or pre-accreditation.

(2) To obtain a new approval period for a current basic midwifery education course, the course administrator must, within [~~Course supervisors/administrators shall reapply for approval~~] six months before the [~~prior to~~] expiration date of the current course approval:[~~.~~]

(A) submit to the department a completed application;

(B) schedule with the department, and successfully pass, an on-site evaluation to occur before the expiration date of the current course approval; and

(C) submit to the department the fee required under §115.80 for the on-site evaluation.

(d) Course changes. A [~~Any~~] substantive change to a basic midwifery course [~~change(s) in the course~~] or its content must be approved by [~~shall be submitted to~~] the department before the change is implemented [~~within ten working days after change(s)~~].

(e) Transfer hours. A basic midwifery education course may accept:

(1) didactic and clinical transfer hours from another basic midwifery education course; and

(2) clinical hours earned under a NARM-certified preceptor.

§115.22. Preceptor Supervisory Responsibilities.

(a) All clinical experience activities performed by a student must be under the direct supervision of a preceptor in accordance with this section.

(1) The student must perform only the activities authorized by the preceptor.

(2) The student must not advertise, or represent to the public in any way, that the student is a midwife.

(3) The student must not receive compensation from a client for performing supervised activities.

(4) Before any service involving a student is provided to a client:

(A) the client must be informed in writing of:

(i) the requirements of this section;

(ii) the identity and license status of the preceptor and the student;

(iii) the services that will be provided under direct supervision to the client; and

(B) the client must consent in writing to the services being provided under direct supervision.

(b) A student acting under direct supervision in accordance with this section is not practicing midwifery in violation of the requirement to hold a license.

(c) A licensed midwife providing direct supervision of a student is responsible for all actions and liabilities of the student.

§115.23. Jurisprudence Examination.

(a) - (c) (No change.)

(d) The department may contract with a vendor to administer the examination. Examination fees will be determined by the vendor contract and will be posted on the department's website. Reexaminations will be made available as necessary. The department or the contracting vendor will grade the examination and provide notice of results to the individual who took the examination.

§115.25. Continuing Education.

All continuing education taken by midwives for the purpose of obtaining or renewing a midwifery license must be in accordance with this section.

(1) (No change.)

(2) Course curriculum must provide an educational experience which:

(A) covers established knowledge or new developments in the fields of midwifery, [~~or~~] related disciplines; and [~~or~~]

[~~(B) reviews established knowledge in the fields of midwifery or related disciplines; and~~]

(B) [~~(C)~~] shall be presented in standard contact hour increments for continuing health education.[~~; and~~]

[~~(D) shall provide reasonable access for non-English speakers and comply with federal and state laws on accessibility.~~]

(3) (No change.)

(4) Course approval. To be approved by the department, a continuing education course must: [~~Continuing education courses attended to fulfill licensure or license renewal requirements shall be accepted when the courses:~~]

(A) satisfy the requirements of paragraph (2) [~~(2)(A) - (C)~~]; and

(B) be provided or [~~are~~] accredited by one of the following [~~accrediting~~] bodies:

(i) a professional midwifery [~~association~~], nursing, social work, or medical association [~~medicine~~];

(ii) a college, a university, or a [~~an approved~~] basic midwifery education course;

(iii) a nursing, medical, or health care organization;

(iv) a state board of nursing or medicine;

(v) a department of health; or

(vi) a hospital.

§115.70. Standards of Conduct.

The following are grounds for denial of application for licensure or license renewal and for disciplinary action.

(1) The commission or executive director may deny an application for initial licensure or license renewal and may take disciplinary action against any person based upon proof of the following:

(A) - (K) (No change.)

[~~(L) a lack of personal or professional character in the practice of midwifery;~~]

(L) [~~(M)~~] failure to use generally accepted standards of midwifery care;

(M) [~~(N)~~] failure to exercise ordinary diligence in the provision of midwifery care;

(N) [~~(O)~~] failure to act competently in the provision of midwifery care; or

(O) [~~(P)~~] a material misrepresentation knowingly made to the department on any matter or to a client during the provision of midwifery care.

(2) (No change.)

(3) The commission or executive director may suspend or revoke course approval if:

(A) the course no longer meets one or more of the standards established by this chapter [~~subsection~~];

(B) the course administrator [~~supervisor~~], an instructor [~~instructor(s)~~], or a preceptor does [~~preceptor(s) do~~] not have the qualifications required by this chapter [~~subsection~~];

(C) course approval was obtained by fraud or deceit;

(D) the course administrator [~~supervisor~~] falsified course registration, attendance, completion and/or other records; or

(E) course approval was based on MEAC accreditation or pre-accreditation that has since been suspended or revoked [~~continued approval of the course is not in the public interest~~].

§115.80. Fees.

All fees must be made payable to the department and are nonrefundable.

(1) Midwife license initial application [~~Application~~] fee--$275

(2) Midwife license renewal application [~~Renewal~~] fee--$550 for each two-year renewal period

(3) (No change.)

(4) Retired voluntary charity care status license initial application [~~midwife renewal~~] fee--$0 [~~$275~~]

(5) Retired voluntary charity care status license renewal application [~~midwife reinstatement~~] fee--$0 [~~$275~~]

(6) (No change.)

(7) Basic midwifery education [~~Education~~] course initial application fee--$150

(8) Basic midwifery education [~~Education~~] course on-site evaluation [~~site visit~~] fee--$500

(9) - (11) (No change.)

§115.100. Standards for the Practice of Midwifery in Texas.

(a) Using reasonable skill and knowledge, the midwife must [~~shall~~]:

(1) - (3) (No change.)

(4) practice in accordance with the knowledge, clinical skills, and judgments described in the current [~~most recently~~] adopted version of the MANA [~~Midwives Alliance of North America (MANA)~~] Core Competencies for Basic Midwifery Practice, within the bounds of the midwifery scope of practice as defined by the Act and this chapter [~~Rules~~];

(b) (No change.)

(c) The midwife shall document midwifery care in legible, complete health records. The midwife shall:

(1) (No change.)

(2) review problems identified by the midwife or by other professionals or consumers in the community; [~~and~~]

(3) act to resolve problems that are identified;[~~.~~]

(4) - (5) (No change.)

(d) (No change.)

§115.120. Newborn Screening.

(a) Each midwife who attends [~~assists at~~] the birth of a child is responsible for collecting blood specimens for [~~performing the~~] newborn screening tests to the extent required by [~~according to~~] the Health and Safety Code, Chapters 33 and 34, and 25 TAC §§37.51 - 37.65, or making a referral in accordance with this subsection. A midwife must not collect blood specimens for the tests without appropriate training. [~~If the midwife performs the tests, then she or he must have been appropriately trained.~~] Each midwife must have one of the following documents on file with the department to maintain licensure [~~in order to be licensed~~].

(1) Midwife Training Certification Form for Newborn Screening Specimen Collection. A midwife who chooses to collect blood specimens for [~~Should the midwife choose to do~~] the newborn screening tests must first [~~she or he will~~] obtain training to collect blood specimens [~~perform this test~~] from an appropriate health care facility. Instruction must [~~will~~] be based upon the procedure for newborn screening developed by the Department of State Health Service's Newborn Screening Program under authority of the Health and Safety Code, Chapter 33, as implemented in 25 TAC, Chapter 37, Subchapter D. At the completion of the instruction for newborn screening blood collection, the midwife must [~~will~~] request that the form Midwife Training Certification Form for Newborn Screening Specimen Collection be signed by the designated representative of the health care facility, attesting to the fact that the midwife has complied with this requirement. This training, as part of the licensure requirements, is only necessary once unless there is a change in screening procedures. A midwife who submits to the department a completed form in compliance with this paragraph is considered approved by the department to collect blood specimens for the newborn screening tests.

(2) (No change.)

(b) As long as the midwife has been approved by the department to perform the newborn screening test, the act of collecting this specimen will not constitute "practicing medicine" as defined by the Medical Practice Act.

(c) [~~As long as one is available, a physician or an appropriately trained professional acting under standing delegation order from a physician at an appropriate health care facility shall instruct midwives in the proper procedure (newborn screening collection procedure of the Department of State Health Services' Newborn Screening Program) for newborn screening blood specimen collection and submission.~~] The physician, or other appropriately trained healthcare provider [~~registered nurse, or any other person~~] who instructs a midwife in the approved techniques for newborn screening on the orders of a physician, is immune from liability arising out of the failure or refusal of a midwife to:

(1) collect and submit the blood specimen in an approved manner; or

(2) send the samples to the laboratories designated by the Department of State Health Services in a timely manner.

(d) (No change.)

§115.121. Informed Choice and Disclosure Statement.

(a) A midwife must use the form prescribed by the department to meet the written informed choice and disclosure requirements of §203.351 of the Act.

(b) The content of the form described in subsection (a) must be provided to a prospective client in both oral and written form before any midwifery service is provided.

(c) A student performing clinical experience activities must have informed consent as required by §115.22.

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 April 3, 2023.

TRD-202301264
Della Lindquist
Interim General Counsel
Texas Department of Licensing and Regulation
Earliest possible date of adoption: May 14, 2023
For further information, please call: (512) 463-7750

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16 TAC §§115.2, 115.16, 115.121

STATUTORY AUTHORITY

The proposed repeal is proposed under Texas Occupations Code, Chapters 51 and 203, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The proposed rules are also proposed under Texas Government Code, Chapter 411, Subchapter F, and Texas Occupations Code, Chapters 51 and 53, which establish the Department's statutory authority to conduct criminal history background checks on an applicant for or a holder of a license, certificate, registration, title, or permit issued by the Department. The proposed rules are also proposed under Texas Occupations Code, Chapter 112, which requires the adoption of rules providing for reduced fees and continuing education requirements for a retired health care practitioner whose only practice is voluntary charity care.

The statutory provisions affected by the proposed repeal is those set forth in Texas Occupations Code, Chapters 51 and 203, and Texas Government Code, Chapter 411, Subchapter F. No other statutes, articles, or codes are affected by the proposed repeal.

§115.2. License Required.

§115.16. Renewal for Retired Midwives Performing Charity Work.

§115.121. Informed Choice and Disclosure Statement.

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

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Della Lindquist
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Texas Department of Licensing and Regulation
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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 89. ADAPTATIONS FOR SPECIAL POPULATIONS

SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING SPECIAL EDUCATION SERVICES

DIVISION 2. CLARIFICATION OF PROVISIONS IN FEDERAL REGULATIONS

19 TAC §89.1050

The Texas Education Agency (TEA) proposes an amendment to §89.1050, concerning the admission, review, and dismissal (ARD) committee. The proposed amendment would provide clarification to the existing regulation regarding students who register in a new school district during the summer months, as well as students who transfer to a new district during the school year. Additionally, the proposed amendment would clarify the federal requirement to ensure that a parent who is unable to meaningfully participate in English is still able to understand the proceedings of the ARD committee and receives proper notice in the parent's native language or other mode of communication.

BACKGROUND INFORMATION AND JUSTIFICATION: Section 89.1050 describes ARD committee requirements for a child who receives special education and related services.

The proposed amendment to §89.1050 would provide clarification based on requests from school districts regarding students who register in a new district during the summer months. Additionally, the amendment would clarify an ARD committee's duties when a parent is deaf or hard of hearing or whose native language is not English. Specifically, the following changes would be made.

The proposed amendment would remove an outdated cross reference to 34 Code of Federal Regulations (CFR), §300.18, in subsection (c)(2) and would amend subsections (f) and (g) to require the school district to take action, including arranging for an interpreter for parents who are deaf or hard of hearing or whose native language is a language other than English, to ensure parent understanding when a parent is unable to meaningfully participate in the ARD process.

The proposed amendment to subsection (j) would clarify ARD committee responsibilities when a student transfers to a new school district during the school year or registers in a new district during the summer months.

The proposed amendment to subsection (j)(1) would address requirements for a student transferring within the state in the same school year with an individualized education program (IEP) in effect in the student's previous district. The proposed amendment would also change the timeline for completing the requirements of 34 CFR, §300.323(e)(1) or (2), from 30 school days to 30 calendar days to align with the proposed new definition of "verify" in subsection (j)(6).

The proposed amendment to subsection (j)(2) would address a student who transfers from a district in another state in the same

school year with an IEP in effect in the student's previous district. The proposed amendment would also change the timeline for completing the requirements of 34 CFR, §300.323(f)(2), from 30 school days to 30 calendar days to align with the proposed new definition of "verify" in subsection (j)(6).

The proposed amendment to subsection (j)(3) would require the new school district to take reasonable steps to obtain the student's previous records in a timely manner.

The proposed amendment to subsection (j)(4) would address a student who registers in a new district in the summer months. It would require the new school district to implement the IEP from the previous district if the parents or in- or out-of-state district verify the previous IEP before the new school year, and it would also require that the timelines in subsection (j)(1) and (2) apply to any student with an unverified eligibility for special education services before the start of the new school year.

Proposed new subsection (j)(5) would address additional requirements for a student who transfers to a new school district during the summer months . If the new district wishes to convene an ARD meeting to consider revision to the student's IEP before the start of the school year, a new provision is proposed that would require the district to determine if the student's parent will agree to waive the five school-day notice, and, if the parent agrees, to make every reasonable effort to hold the ARD meeting prior to the first day of the new school year.

Proposed new subsection (j)(6) would add a new definition of "verify" to mean that the new school district has received a copy of the student's IEP that was in effect in their previous district. Because of this specific definition, timelines associated with developing, adopting, and implementing a new IEP for a student who transfers during the school year are proposed to change from school days to calendar days in subsection (j)(1) and (2) to comply with the expectations of an ARD committee once an evaluation is complete for any student.

Proposed new subsection (j)(7) would provide instruction for the new district awaiting verification to take reasonable steps, with the consultation of the student's parent, to provide comparable services received by the student in the previous district if the new district is aware of the student's placement.

FISCAL IMPACT: Justin Porter, associate commissioner and chief program officer for special education programs and policy, has determined that for the first five-year period the proposal is in effect, there are no additional costs to state or local government, including school districts and open-enrollment charter schools, beyond what is required by federal Individuals with Disabilities Education Act (IDEA) regulations. While a school district may be required to incur costs such those related to holding an ARD committee meeting during the summer and providing interpreters, these costs are required not by rule but by IDEA's requirement that an IEP must be in effect at the beginning of the school year for all eligible students with a disability and that parents fully understand the IEP proceedings.

LOCAL EMPLOYMENT IMPACT: The proposal has no effect on local economy; therefore, no local employment impact statement is required under Texas Government Code, §2001.022.

SMALL BUSINESS, MICROBUSINESS, AND RURAL COMMUNITY IMPACT: The proposal has no direct adverse economic impact for small businesses, microbusinesses, or rural communities; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

COST INCREASE TO REGULATED PERSONS: The proposal does not impose a cost on regulated persons, another state agency, a special district, or a local government and, therefore, is not subject to Texas Government Code, §2001.0045.

TAKINGS IMPACT ASSESSMENT: The proposal does not impose a burden on private real property and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

GOVERNMENT GROWTH IMPACT: TEA staff prepared a Government Growth Impact Statement assessment for this proposed rulemaking. During the first five years the proposed rulemaking would be in effect, it would expand an existing regulation to clarify the process a school district must follow when a student receiving special education services transfers to a different district during the school year or during the summer. Additionally, it would clarify how LEAs must ensure parents are able to meaningfully participate in an IEP and ARD committee meetings.

The proposed rulemaking would not create or eliminate a government program; would not require the creation of new employee positions or elimination of existing employee positions; would not require an increase or decrease in future legislative appropriations to the agency; would not require an increase or decrease in fees paid to the agency; would not create a new regulation; would not limit or repeal an existing regulation; would not increase or decrease the number of individuals subject to its applicability; and would not positively or adversely affect the state's economy.

PUBLIC BENEFIT AND COST TO PERSONS: Mr. Porter has determined that for each year of the first five years the proposal is in effect, the public benefit anticipated as a result of enforcing the proposal would be to provide clarification to school districts on the processes required when students transfer to a new district during the school year and when students register in a new district during the summer months. Additionally, the proposal would clarify requirements to ensure meaningful parent participation. There is no anticipated economic cost to persons who are required to comply with the proposal.

DATA AND REPORTING IMPACT: The proposal would have no data and reporting impact.

PRINCIPAL AND CLASSROOM TEACHER PAPERWORK REQUIREMENTS: TEA has determined that the proposal would not require a written report or other paperwork to be completed by a principal or classroom teacher.

PUBLIC COMMENTS: The public comment period on the proposal begins April 14, 2023, and ends May 15, 2023. Two public hearings to solicit testimony and input on the proposed amendment will be held at 9:00 a.m. on April 26 and May 1, 2023, via Zoom. The public may participate in either hearing virtually by linking to the hearing at https://zoom.us/j/7366629670 or joining by SIP at 7366629670@zoomcrc.com. The public may attend one or both hearings. Anyone wishing to testify at one of the hearings must sign in between 8:30 a.m. and 9:00 a.m. on the day of the respective hearing. Each hearing will conclude once all who have signed in have been given the opportunity to comment. Each individual's comments are limited to three minutes, and each individual may comment only once. Both hearings will be recorded and made available publicly. Questions about the hearings should be directed to kristin.mcguire@tea.texas.gov. A form for submitting public comments is available on the TEA website at https://tea.texas.gov/About_TEA/Laws_and_Rules/Com-

missioner_Rules_(TAC)/Proposed_Commissioner_of_Education_Rules/.

STATUTORY AUTHORITY. The amendment is proposed under Texas Education Code (TEC), §29.001, which requires the agency to ensure that the statewide design for special education ensures that a free appropriate public education is available to all eligible students with a disability, including that individualized education programs are properly developed, implemented, and maintained in the least restrictive environment that is appropriate to meet the student's educational needs; 34 Code of Federal Regulations (CFR), which §300.322, requires actions to ensure that parents understand the proceedings of the IEP team meeting, including arranging for interpreters; and 34 CFR, §300.323, which requires an individualized education program to be in effect at the beginning of each school year for a child with a disability, with limited exception.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §29.001; and 34 Code of Federal Regulations (CFR), §300.322 and §300.323.

§89.1050. The Admission, Review, and Dismissal Committee.

(a) - (b) (No change.)

(c) ARD committee membership.

(1) (No change.)

(2) The special education teacher or special education provider that participates in the ARD committee meeting must be appropriately certified or licensed as required by 34 CFR, [~~§300.18 and~~] §300.156.

(3) - (4) (No change.)

(d) - (e) (No change.)

(f) The [~~If the parent is unable to speak English, the~~] school district must provide the parent with a written notice required under subsection (d) or (e)(2) of this section in the parent's native language, unless it is clearly not feasible to do so. If the parent's native language is not a written language, the school district must take steps to ensure that the notice is translated orally or by other means to the parent in his or her native language or other mode of communication so that the parent understands the content of the notice.

(g) All members of the ARD committee must have the opportunity to participate in a collaborative manner in developing the IEP. The school district must take whatever action is necessary to ensure that the parent understands the proceedings of the ARD committee meeting, including arranging for an interpreter for parents who are deaf or hard of hearing or whose native language is a language other than English. A decision of the ARD committee concerning required elements of the IEP must be made by mutual agreement if possible. The ARD committee may agree to an annual IEP or an IEP of shorter duration.

(1) - (4) (No change.)

(h) - (i) (No change.)

(j) A school district must comply with the following for a student who is new to the school district.

(1) When a student transfers to a new school district within the state in the same school year and the parents or previous school district verifies [~~verify~~] that the student had an IEP that was in effect in the previous district [~~was receiving special education services in the previous school district or the previous school district verifies in writing or by telephone that the student was receiving special education services~~] , the new school district must meet the requirements of 34 CFR, §300.323(e), regarding the provision of special education services. The timeline for completing the requirements outlined in 34 CFR, §300.323(e)(1) or (2), is 30 calendar [~~school~~] days from the date the student is verified as being a student eligible for special education services.

(2) When a student transfers from a school district in another state in the same school year and the parents or previous school district verifies [~~verify~~] that the student had an IEP that was in effect in the previous district [~~was receiving special education services in the previous school district or the previous school district verifies in writing or by telephone that the student was receiving special education services~~] , the new school district must meet the requirements of 34 CFR, §300.323(f), regarding the provision of special education services. If the new school district determines that an evaluation is necessary, the evaluation is considered a full individual and initial evaluation and must be completed within the timelines established by §89.1011(c) and (e) of this title. The timeline for completing the requirements in 34 CFR, §300.323(f)(2), if appropriate, is 30 calendar days from the date of the completion of the evaluation report. If the school district determines that an evaluation is not necessary, the timeline for completing the requirements outlined in 34 CFR, §300.323(f)(2), is 30 calendar [~~school~~] days from the date the student is verified as being a student eligible for special education services.

(3) In accordance with [~~TEC, §25.002, and~~] 34 CFR, §300.323(g), the new school district must take reasonable steps to promptly obtain the student's records from the previous school district, and, in accordance with TEC, §25.002, and 34 CFR, §300.323(g), the previous school district [~~in which the student was previously enrolled~~] must furnish the new school district with a copy of the student's records, including the student's special education records, not later than the 10th working day after the date a request for the information is received by the previous school district.

(4) A student [~~with a disability who has an IEP in place from a previous in- or out-of-state school district and~~] who registers [~~enrolls~~] in a new school district during the summer is not considered a transfer student for the purposes of this subsection or for 34 CFR, §300.323(e) or (f). For these students, if the parents or in- or out-of-state school district verifies before the new school year begins that the student had an IEP that was in effect in the previous district, the new school district must implement the IEP from the previous school district in full on the first day of class of the new school year or must convene an ARD committee meeting during the summer to revise the student's IEP for implementation on the first day of class of the new school year. If the student's eligibility for special education and related services cannot be verified before the start of the new school year, the timelines in paragraphs (1) and (2) of this subsection apply to the student.

(5) In the case of a student described by paragraph (4) of this subsection, if the new district wishes to convene an ARD committee meeting to consider revision to the student's IEP before the beginning of the school year, the new district must determine whether the parent will agree to waive the requirement in subsection (d) of this section that the written notice of the ARD committee meeting must be provided at least five school days before the meeting. If the parent agrees to a shorter timeframe, the new district must make every reasonable effort to hold the ARD committee meeting prior to the first day of the new school year if the parent agrees to the meeting time.

(6) For the purposes of this subsection, "verify" means that the new school district has received a copy of the student's IEP that was in effect in the previous district.

(7) While the new school district waits for verification, the new school district must take reasonable steps to provide, in consulta-

tion with the student's parents, services comparable to those the student received from the previous district if the new school district has been informed by the previous school district of the student's special education and related services and placement.

(k) (No change.)

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

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Texas Education Agency
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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER W. CONSUMER PROTECTION REQUIREMENTS CONSUMER BILL OF RIGHTS

28 TAC §5.9970

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §5.9970, concerning the Consumer Bill of Rights for Personal Automobile Insurance (Auto Bill of Rights). Insurance Code §501.156 requires the Office of Public Insurance Counsel (OPIC) to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance that TDI regulates.

EXPLANATION. Under Insurance Code Chapter 501, OPIC represents the interests of insurance consumers in Texas. OPIC is required by Insurance Code §501.156 to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance TDI regulates. These bills of rights explain to consumers how their rights are affected by applicable statutes and rules and are to be distributed by an insurer to each policyholder on issuance of a policy.

TDI received a petition from OPIC on August 30, 2022, requesting adoption of a revised Auto Bill of Rights. The current version was adopted in May 2021 and is found in 28 TAC §5.9970. Since the last amendment, legislation was passed that affects the rights of insurance consumers. Specifically, new Insurance Code §551.1053 requires mandatory nonrenewal of private passenger automobile policies when an insured fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a claim or action. OPIC has determined that this change requires an amendment to the Auto Bill of Rights.

Personal line insurers must distribute the Auto Bill of Rights to each policyholder on issuance of a new policy or on renewal if the updated bill of rights was not previously sent. Amending the Auto Bill of Rights ensures that insurers distribute current consumer rights information to policyholders.

The proposed amendments to the section are described in the following paragraphs.

Section §5.9970. The amendments to §5.9970 update the English and Spanish translation versions of the Auto Bill of Rights and are proposed in subsection (b) as Figure 1: 28 TAC §5.9970(b) and Figure 2: 28 TAC §5.9970(b).

The proposed new English and Spanish translation versions of the Auto Bill of Rights contain changes from the previous versions resulting from legislative actions that affect the rights of insurance consumers. Specifically, Insurance Code §551.1053 was added by Senate Bill 1602, 87th Legislature, 2021, and requires nonrenewal of private passenger automobile insurance policies where an insured fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a claim or action or the insurer is unable to contact the insured using reasonable efforts for those purposes.

These amendments are intended to ensure that the Auto Bill of Rights is consistent with the law and that consumers are informed of their rights related to their personal automobile insurance policies.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. John Mooney, manager of the Property and Casualty Lines Office, has determined that for each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of the enforcement or administration of this proposal.

Mr. Mooney does not anticipate any measurable effect on local employment or the local economy as a result of the enforcement or administration of this proposal because the proposal simply updates documents insurers are already required to provide.

PUBLIC BENEFIT AND COST NOTE. For each of the first five years the proposed amendments are in effect, Mr. Mooney expects public benefits to include consumers receiving an accurate and understandable summary of their rights related to their personal automobile insurance policies and facilitating public awareness of insurance consumer rights.

Mr. Mooney expects that the proposed amendments will impose an economic cost on persons required to comply. The cost will vary based on the lines of insurance and number of policyholders for each insurer.

Insurance Code §501.156 and TDI rules require insurers to deliver the Auto Bill of Rights to policyholders at the time a policy is issued or renewed. Because the proposed amendment updates existing documents already required to be provided with insurance policies, the amendment does not impose additional duties regarding new policies. Insurers must provide policyholders with copies of the updated Auto Bill of Rights at the first renewal after the updated bill of rights is effective.

If the insurer and policyholder both consent to electronic delivery under Insurance Code Chapter 35, the insurer may send the updated Auto Bill of Rights electronically, avoiding paper and printing costs. If an insurer prints paper copies of the Auto Bill of Rights, TDI expects the cost to be between $0.06 and $0.08 per page for printing and paper. The Auto Bill of Rights is seven pages long.

An insurer's cost of complying with this requirement will depend on the number of renewals that the insurer provides and on the

number of paper bills of rights the insurer sends. TDI expects that each insurer will have the information necessary to determine its individual cost, including the number of pages to be printed, in-house printing costs, and commercial printing costs.

TDI does not anticipate additional costs for mailing or electronic distribution because the new bill of rights will be sent out in new and renewal packets that the insurer already sends.

TDI estimates that insurers may face administrative costs associated with updating the Auto Bill of Rights in their systems. While it is not feasible to determine the actual cost of any employees needed to comply with the requirement, TDI estimates that amending the Auto Bill of Rights may require the following resources:

- between four and 10 hours of compliance officer staff time to update internal procedures so the revised Auto Bill of Rights is distributed; and

- between four and 10 hours of computer programming staff time to prepare and test systems to begin distributing the revised Auto Bill of Rights.

Staff costs may vary depending on the skill level required, the number of staff required, and the geographic location where work is done. The 2021 median hourly wage for these positions in Texas was:

- compliance officer, $35.14; and

- computer programmer, $38.92;

as reported by the Texas Wages and Employment Projections database, which is developed and maintained by the Texas Workforce Commission and located at www.texaswages.com/WDAWages.

Information on median wages in other states may be obtained directly from the federal Bureau of Labor Statistics website at www.bls.gov/oes/current/oes_nat.htm.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that this proposal may have an adverse economic effect on any insurers that are small or micro businesses. In data the Texas Comptroller provides for use in calculating the number of small businesses, the Comptroller estimates that there are approximately 630 insurance carriers that are considered small businesses as that term is defined in Government Code §2006.001. This Economic Impact Statement and Regulatory Flexibility Analysis and the cost analysis in the Public Benefit and Cost Note section of this proposal applies to the portion of insurance carriers that write personal automobile insurance policies and are small and micro businesses. The total cost to an insurer in providing the revised Auto Bill of Rights to its policyholders is not wholly dependent on the size of the insurer. Instead, the cost depends on the insurer's number of current and future policyholders. TDI does not anticipate an impact on any rural communities because the requirement to distribute bills of rights under Insurance Code §501.156 applies to insurers, not to rural communities.

In accordance with Government Code §2006.002(c-1), TDI considered the following alternatives to minimize any adverse impact on small or micro businesses while still accomplishing the proposal's objectives:

(1) TDI considered not proposing the new rules, but Insurance Code §501.156 requires OPIC to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance TDI regulates. The statute requires these consumer bills of rights to be distributed upon issuance of a policy by insurers to all applicable policyholders. Updating the Auto Bill of Rights is necessary to reflect legislative and regulatory actions that affect the rights of insurance policyholders despite any possible impact on small or micro businesses. To ensure compliance with the statutory requirements, TDI rejected this option.

(2) TDI also considered imposing different rules for small or micro businesses, but ultimately rejected this option for the reason previously stated. The proposed amendment is necessary to comply with statutes and rules that require all insurers to issue the Auto Bill of Rights to policyholders on issuance of a new or renewal policy. These statutory requirements apply to all personal automobile insurers, regardless of size, and cannot be waived or modified for small or micro businesses.

(3) Finally, TDI considered exempting small or micro businesses from the rule requirement, but ultimately rejected this option for the reason previously stated. The purpose of any consumer bill of rights is to notify each policyholder of their rights applicable to those personal lines of insurance. Insurance Code §501.156 requires OPIC to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance that TDI regulates. These statutory requirements apply to all personal automobile insurers, regardless of size, and cannot be waived or modified for small or micro businesses.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does impose a possible cost on regulated persons. However, no additional rule amendments are required under Government Code §2001.0045 because publishing the Auto Bill of Rights is necessary to implement Insurance Code §501.156, based on the addition of new §551.1053 to the Insurance Code. Section 501.156 requires OPIC to submit for adoption a consumer bill of rights appropriate to each personal line of insurance TDI regulates.

Although the Auto Bill of Rights was last updated in 2021, recent legislative action has affected the rights of personal automobile insurance consumers. Specifically, Insurance Code §551.1053 was added by Senate Bill 1602, and it requires nonrenewal of private passenger automobile insurance policies where an insured fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a claim or action or the insurer is unable to contact the insured using reasonable efforts for those purposes.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years the amendments are in effect, the amendments:

-will not create or eliminate a government program;

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

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

-will not require an increase or decrease in fees paid to the agency;

-will not create a new regulation;

-will not expand, limit, or repeal an existing regulation;

-will not increase or decrease the number of individuals subject to the rule's applicability; and

-will not positively or adversely affect the Texas economy.

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 or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments for the proposal that are received by TDI no later than 5:00 p.m. Central time, on May 15, 2023. Send your comments to ChiefClerk@tdi.texas.gov or by mail to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a separate request before the end of the comment period to ChiefClerk@tdi.texas.gov or by mail to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

STATUTORY AUTHORITY. TDI proposes amendments to §5.9970 under Insurance Code §§501.156, 551.1053, and 36.001.

Insurance Code §501.156 requires OPIC to submit to TDI for adoption a consumer bill of rights appropriate to each personal line of insurance TDI regulates.

Insurance Code §551.1053 requires nonrenewal of private passenger automobile insurance policies where an insured fails or refuses to cooperate with an insurer in the investigation, settlement, or defense of a claim or action or the insurer is unable to contact the insured using reasonable efforts for those purposes.

Insurance Code §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. Section 5.9970 implements Insurance Code §501.156 and §551.1053.

§5.9970. Personal Automobile Insurance Consumer Bill of Rights.

(a) For purposes of this section, "insurer" means an insurance company, reciprocal or interinsurance exchange, mutual insurance company, capital stock company, county mutual insurance company, Lloyd's plan, or other legal entity authorized to write personal automobile insurance in this state. The term includes an affiliate, as described by Insurance Code §823.003(a), if that affiliate is authorized to write and is writing personal automobile insurance in this state.

(b) The Texas Department of Insurance adopts the 2023 [~~2021~~] version of the Consumer Bill of Rights - Personal Automobile Insurance (Auto Bill of Rights), and the Spanish language translation, as developed and submitted by the Office of Public Insurance Counsel:
Figure 1: 28 TAC §5.9970(b)
Figure 2: 28 TAC §5.9970(b)
[~~Figure 1: 28 TAC §5.9970(b)~~]
[~~Figure 2: 28 TAC §5.9970(b)~~]

(c) All insurers writing personal automobile insurance policies must provide with each new policy of personal automobile insurance a copy of the 2023 [~~2021~~] version of the Auto Bill of Rights. At the consumer's request, the insurer may provide an electronic copy of the Auto Bill of Rights instead of a hard copy. The insurer must provide the Auto Bill of Rights with each renewal notice for personal automobile insurance unless the insurer has previously provided the policyholder with the 2023 [~~2021~~] version of the Auto Bill of Rights.

(d) The Auto Bill of Rights must appear in no less than 10-point type and be on separate pages with no other text on those pages.

(e) Insurers must provide the Spanish language version of the 2023 [~~2021~~] version of the Auto Bill of Rights to any consumer who requests it.

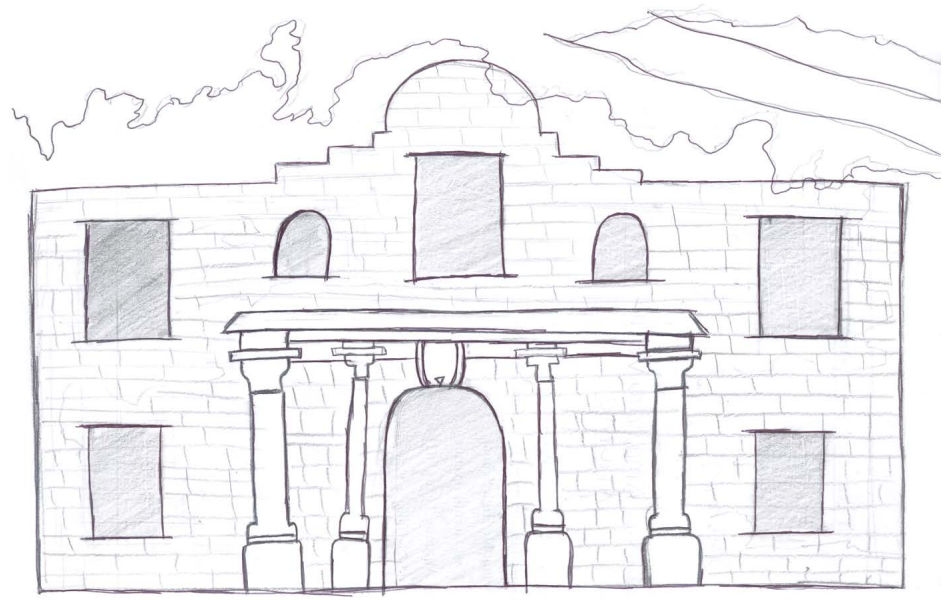
(f) Insurers must provide the applicable Auto Bill of Rights included in this section beginning January 1, 2024 [~~November 15, 2021~~]. Before that date, insurers may provide the Auto Bill of Rights either as it is currently included in this section or as it was included in the section as the section was amended to be effective May 16, 2021 [~~January 31, 2013~~].

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 March 30, 2023.

TRD-202301226
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: May 14, 2023
For further information, please call: (512) 676-6587

♦ ♦ ♦



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 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 23. COMMODITY PRODUCERS BOARDS

The Texas Department of Agriculture (Department) adopts amendments to 4 Texas Administrative Code, §§23.1, 23.21 - 23.23, 23.25, 23.41 - 23.43, 23.100, 23.101, 23.103 - 23.107 and the repeal of §§23.24, 23.26, 23.40, 23.44, 23.102, 23.200, 23.201, 23.220, 23.221, 23.230 - 23.234, 23.240 - 23.248, 23.260 - 23.266, 23.280 and 23.281. The amendments and repeals are adopted without changes to the proposed text as published in the November 18, 2022, issue of the *Texas Register* (47 TexReg 7622) and will not be republished.

The amendments to §23.1 remove unnecessary definitions already contained in Title 4, Part 1, Chapter 1 that apply to the entire part and provides that the definitions contained in Texas Agriculture Code, Chapter 41, Subchapter A also apply to this chapter. The amendments also add a definition for "commodity process point."

The amendments to §23.21 remove language that is duplicative of sections in Texas Agriculture Code, Chapter 41 and breaks existing text into paragraphs for clarity.

The amendments to §23.22 and §23.23 remove the requirement for notice of referenda or elections to be published in newspapers and industry publications in order to reduce costs but increase the number of methods that can be used to provide notice to producers, which can include print and electronic means. The amendments provide that referenda to add new territory to boards' jurisdiction will be conducted pursuant to Texas Agriculture Code, §41.034, which has specific requirements to add territory, and make editorial changes for clarity.

The repeal of §23.24 is adopted because it is duplicative of Texas Agriculture Code, §41.033.

The amendments to §23.25 make editorial changes and clarifies language to align with the rulemaking authority provided by Texas Agriculture Code, Chapter 41.

The repeal of §23.26 is adopted because it is duplicative of Texas Agriculture Code, §41.051.

The repeal of §23.40 is adopted because it is duplicative of Texas Agriculture Code, §41.059(a).

The amendments to §§23.41 - 23.43 make editorial changes and replaces "verifies" with "certifies" to utilize terminology consistent with Texas Agriculture Code, Chapter 41.

The repeal of §23.44 is adopted because it is duplicative of Texas Agriculture Code, §41.102.

The amendments to §23.100 replaces "Texas Beef Check-off referendum program" with "state beef check off program" to utilize terminology consistent with Texas Agriculture Code, Chapter 41; changes the name of the entity that is the subject of the subchapter to be consistent with Texas Agriculture Code, Chapter 41; and makes an editorial change.

The amendments to §23.101 replaces a definition for "collection point" with "commodity process point" to utilize terminology consistent with Texas Agriculture Code, Chapter 41 and removes the definition for "producer," a term already defined in Texas Agriculture Code, §41.151(3).

The repeal of §23.102 is adopted because it is duplicative of Texas Agriculture Code, §41.162(a).

The amendments to §23.103 repeal subsections that are duplicative of text in Texas Agriculture Code Chapter 41 and make editorial changes.

The amendments to §23.104 remove an unnecessary requirement for the Beef Promotion and Research Council of Texas to provide copies of any resolutions adopted in its annual report to the Department and make editorial changes.

The amendments to §23.105 changes "collection point" and "collecting person" to "commodity process point" to utilize terminology consistent with Texas Agriculture Code, Chapter 41.

The amendments to §23.106 changes "collection point" to "commodity process point" to utilize terminology consistent with Texas Agriculture Code, Chapter 41; makes editorial changes; and clarifies when an application for refund of an assessment paid by a cattle producer is considered timely.

The amendments to §23.107 creates a provision for the Beef Promotion and Research Council of Texas to use data to determine an assessment in the event of a failure to remit assessments and makes editorial changes.

The repeal of Subchapter C, concerning the Texas Grain Producer Indemnity Board, is adopted because the Texas Grain Producer Indemnity Board (Board) is inactive and no business necessity exists for the subchapter. Additionally, Texas Agriculture Code, Chapter 41, Subchapter I provides nearly all rulemaking authority to the Board, not the Department. Board rules were previously located primarily in Title 4, Part 6, prior to being repealed and adopted as Subchapter C.

The Department also adopts changes to the title of the chapter, the title of divisions 1-3 of subchapter A, the title of subchapter B, and the rule headings of §§23.22, 23.25, 23.41, 23.42, and 23.107.

Public Comment

The Department received one comment from the Texas Press Association (TPA) opposing some of the proposed changes to §§23.22 and 23.23. The TPA commented that the proposed changes would remove the requirement that notice of referenda and board elections be published in newspapers and industry publications with preference to the areas of the greatest production of the specific commodity, thereby decreasing the likelihood an eligible individual would be aware of these elections. The TPA argues the means by which public notice must be given is largely left to the discretion of the nonprofit organization conducting the referendum or election under the proposed changes.

Response

The Department disagrees that notice in a newspaper is necessary in all situations to provide adequate notice of referenda and board elections. The Department also disagrees that notice will be left to the discretion of certified organizations or boards. The proposed changes grant additional flexibility, but the Department will retain responsibility for the approval of election plans under §23.22, including how notice of a referendum and/or election will be provided, to ensure adequate notice will be provided. In some instances, publication of notice in a newspaper may be appropriate, but there are alternatives to newspapers that provide a higher likelihood of producers receiving actual notice of a referendum or election. Industry organizations/associations routinely send out newsletters and other correspondence through electronic means or physical mail to producers from lists gathered through the Farm Service Agency Texas State Office. Providing notice through these newsletters or other correspondence has a high probability of reaching producers with active interests in the commodities that are the subject of biennial elections and referenda.

The Department also notes that notice must be provided to each county extension agent in any county within the boundaries in which the referendum or election will take place. County extension agents throughout the state typically publish articles in local newspapers on a regular basis (weekly or monthly). These articles are targeted to and likely to be read by local producers. Therefore, the provision of notice to county extension agents allows them to write about upcoming referenda or elections. County extension agents have a vested interest in the commodities and the local producers they serve and are frequently personally known by the producers, therefore articles written by extension agents will reach more producers than notice in the classified advertisements section of a newspaper. Not only will these articles reach more producers through readership, but the articles are also typically in more publications than the current rules require.

For the above reasons, the Department has concluded the amendments provide a more efficient and economical route to providing notice to commodity producers than the current rules. Accordingly, the Department declines to modify the proposed text.

SUBCHAPTER A. GENERAL PROVISIONS
DIVISION 1. DEFINITIONS

4 TAC §23.1

The amendments are adopted under Texas Agriculture Code, §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

Filed with the Office of the Secretary of State on March 30, 2023.

TRD-202301234
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: April 19, 2023
Proposal publication date: November 18, 2022
For further information, please call: (512) 936-9360

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DIVISION 2. REFERENDA AND ELECTIONS

4 TAC §§23.21 - 23.23, 23.25

The amendments are adopted under Texas Agriculture Code §41.022, which provides the commissioner shall adopt rules regulating the form of the ballot, the conduct of the election, and the canvass and reporting of returns; Texas Agriculture Code §41.023, which provides the commissioner by rule shall prescribe the manner for providing public notice under Texas Agriculture Code Texas Agriculture Code §41.023(a); Texas Agriculture Code §41.032, which provides commodity producers boards shall conduct biennial elections in accordance with the rules of the commissioner; and Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 2. CERTIFICATION OF COMMODITY ORGANIZATIONS

4 TAC §23.24, §23.26

The repeals are adopted under Texas Agriculture Code §41.022, which provides the commissioner shall adopt rules regulating the form of the ballot, the conduct of the election, and the canvass and reporting of returns and Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
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For further information, please call: (512) 936-9360

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DIVISION 3. BUDGET APPROVAL AND COMMODITY ASSESSMENTS

4 TAC §23.40, §23.44

The repeals are adopted under Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 3. ASSESSMENTS

4 TAC §§23.41 - 23.43

The amendments are adopted under Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
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For further information, please call: (512) 936-9360

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SUBCHAPTER B. BEEF PROMOTION AND RESEARCH COUNCIL OF TEXAS

4 TAC §§23.100, 23.101, 23.103 - 23.107

The amendments are adopted pursuant to Texas Agriculture Code §41.163, which provides the commissioner may adopt rules as necessary to implement Texas Agriculture Code, Chapter 41, Subchapter H.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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SUBCHAPTER B. TEXAS BEEF PROMOTION AND RESEARCH COUNCIL

4 TAC §23.102

The repeal is adopted pursuant to Texas Agriculture Code §41.163, which provides the commissioner may adopt rules as necessary to implement Texas Agriculture Code, Chapter 41, Subchapter H.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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SUBCHAPTER C. TEXAS GRAIN PRODUCER INDEMNITY BOARD
DIVISION 1. GENERAL PROVISIONS

4 TAC §23.200, §23.201

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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DIVISION 2. ELECTIONS AND REFERENDUM

4 TAC §23.220, §23.221

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 3. BOARD MEMBERS AND MEETINGS

4 TAC §§23.230 - 23.234

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 4. PRODUCER ASSESSMENTS

4 TAC §§23.240 - 23.248

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 5. CLAIMS

4 TAC §§23.260 - 23.266

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

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Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
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For further information, please call: (512) 936-9360

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DIVISION 6. APPEALS AND REMEDIES

4 TAC §23.280, §23.281

The repeals are adopted pursuant to Texas Agriculture Code §12.016, which provides the Department may adopt rules as necessary for the administration of its powers and duties under the Texas Agriculture Code.

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

Filed with the Office of the Secretary of State on March 30, 2023.

TRD-202301246
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: April 19, 2023
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For further information, please call: (512) 936-9360

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TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 33. LICENSING
SUBCHAPTER E. EVENTS AT A TEMPORARY LOCATION

16 TAC §33.81

The Texas Alcoholic Beverage Commission (TABC, agency, or commission) adopts §33.81, related to Purchase of Alcoholic Beverages for Temporary Events, with a nonsubstantive change to the text published in the December 2, 2022, *Texas Register* (47 TexReg 8013). The rule will be republished.

After legislative changes to the commission's statutory menu of licenses and permits, members of the regulated industry expressed some confusion as to where a Mixed Beverage permit holder can purchase alcoholic beverages for an event held at a temporary location that is not in the same county as the permit holder's primary licensed premises. The commission proposed new §33.81 to clarify that all alcoholic beverages can be purchased in the county of the event, with appropriate recordkeeping. Alcoholic beverages that the permit holder has in stock may also be transported to the event site.

As adopted, §33.81(c) is changed from the proposed text to clarify that a statutory reference is to the Alcoholic Beverage Code.

One comment was received from a representative of the Sonora Economic Development Corporation in favor of the proposal with changes.

Comment: The commenter requests that the proposed rule be changed so that mixed beverage permit holders would only be allowed to sell alcoholic beverages at a temporary event that were purchased from authorized sellers in the county in which the temporary event is to be held. The commenter believes that without such a restriction, rural communities will be negatively impacted by the proposed rule.

Agency Response: TABC declines to make any change in response to this comment. As proposed, §33.81(b)(1) already would require a mixed beverage permit holder purchasing alcoholic beverages for a temporary event to be held in a county other than the permit holder's primary county to purchase the alcoholic beverages from an authorized seller in the county where the temporary event is to be held. It appears that the commenter's issue is with §33.81(d), which provides that the rule does not prevent permit holders from transporting alcoholic beverages already in stock at its primary location to a temporary event to be sold there. Mixed beverage permit holders are authorized by law to transfer alcoholic beverages to their permitted premises. Tex. Alco. Bev. Code §28.07(d). TABC believes proposed §33.81(d) is a reasonable interpretation of that law. Additionally, while the commenter expresses a belief that rural communities will be harmed economically by allowing permit holders to transport alcoholic beverages that are already in stock to the temporary event site, TABC believes that striking the transportation option from the proposed rule would likely result in direct economic harm to permit holders. As such, TABC believes it is appropriate to reduce the regulatory burden on permit holders and not make the requested change.

The rule is adopted pursuant to the commission's authority under §5.31 of the Alcoholic Beverage Code to prescribe and publish rules necessary to carry out the provisions of that Code.

The adopted rule does not impact any other current rules or statutes.

§33.81. Purchase of Alcoholic Beverages for a Temporary Event.

(a) This section applies to holders of Mixed Beverage Permits when selling alcoholic beverages at an event authorized by a Temporary Event Approval or under a File and Use Notification.

(b) Except as provided by subsection (c) of this section, a Mixed Beverage Permit holder purchasing alcoholic beverages for an event at a temporary location in a county other than the county in which the premises covered by its primary permit is located must:

(1) purchase the alcoholic beverages from a seller authorized under this code to sell the alcoholic beverages to members of the retail tier in the county in which the permit holder sells the alcoholic beverages under this section; and

(2) keep a record of the amount of alcoholic beverages purchased and sold under this section, by type, for no less than two years following the last day of the event.

(c) If the temporary event is held in a county that includes more than one territory, as that term is defined by Alcoholic Beverage Code §102.71(5), a Mixed Beverage Permit holder must purchase malt beverages from the distributor holding the territorial agreement covering the temporary event location.

(d) This section does not preclude a Mixed Beverage Permit holder from transporting alcoholic beverages in stock at its primary location to a temporary event.

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 March 28, 2023.

TRD-202301195
James Person
General Counsel
Texas Alcoholic Beverage Commission
Effective date: April 17, 2023
Proposal publication date: December 2, 2022
For further information, please call: (512) 206-3230

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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 102. EDUCATIONAL PROGRAMS
SUBCHAPTER MM. COMMISSIONER'S RULES CONCERNING SUPPLEMENTAL SPECIAL EDUCATION SERVICES PROGRAM

19 TAC §102.1061

The Texas Education Agency (TEA) adopts an amendment to §102.1601, concerning supplemental special education services (SSES) and instructional materials program for certain public school students receiving special education services. The amendment is adopted with changes to the proposed text as

published in the January 20, 2023 issue of the *Texas Register* (48 TexReg 195) and will be republished. The adopted amendment reflects a grant source change and provides clarification.

REASONED JUSTIFICATION: Senate Bill (SB) 1716, 87th Texas Legislature, Regular Session, 2021, added Texas Education Code (TEC), Chapter 29, Subchapter A-1, which established the SSES program. The program is designed to address concerns that have arisen as a result of the coronavirus pandemic for students receiving special education services. It provides additional funds for eligible students who are served in special education to use for supplemental services and materials. These supplemental services and materials are not and cannot be considered as part of the provision of a free appropriate public education as set out in a student's individualized education program. The SSES program expires September 1, 2024.

Under SB 1716, the commissioner of education was required to establish rules to implement and administer the SSES program, and §102.1601 was adopted to establish the parameters to allow eligible students to be provided with funds that may be used for goods and services with TEA-approved providers and vendors. In accordance with statute, certain eligible students are given priority based on enrollment in a school district or open-enrollment charter school that is eligible for a compensatory education allotment. In addition, TEA prioritizes applicants with economic need based on qualification for the National School Lunch Program. The adopted amendment updates the rule as follows.

Subsection (b)(2) is amended to remove reference to the federally funded SSES grant and instead refer to any SSES grant, including the state-funded SSES grant. This change reflects that grant funds may have multiple sources.

Subsections (c)(1), (e)(3)(C), and (f)(1) were amended to reflect an award amount of up to $1500 in state funds with the possibility of additional federal funds depending on eligibility and availability. This change reflects the use of state grant funds under TEC, §29.042, as well as the potential use of additional federal grant funds, subject to eligibility and availability of such federal funds, for a grant program addressing the needs of medically fragile children. At adoption, the language in subsection (e)(3)(C) was changed from "no more than $1,500" to "up to $1,500" for consistency within the rule.

Subsection (c) was also amended to move information related to the use of the National School Lunch Program for need-based qualification from subsection (c)(1) to new subsection (c)(3). Based on public comment, subsection (c)(3) was amended at adoption to remove the phrase "as necessary" when prioritizing those who qualify for the National School Lunch Program. To align with current agency practice, new subsection (c)(2) was added to reflect that TEA uses Public Education Information Management System (PEIMS) codes to verify award eligibility.

New subsection (f)(4) has been added to specify that parents and guardians who receive an award notification but whose student no longer qualifies for the SSES program must notify TEA of the student's change in eligibility status. This change ensures that grant funds are provided only to eligible students.

Subsection (g)(6) was amended to include a reference to guardians when referencing parents. This change ensures references to parents and guardians are consistent throughout the rule.

Subsection (h) was amended to remove the provision that SSES accounts are suspended when account holders do not begin spending funds from their accounts within six months after account creation. This change allows for spending period fluctuations and ensure flexibility based on appropriations, waiting lists, and programmatic need.

Based on public comment, subsection (i) has been revised at adoption to clarify the responsibilities of a student's admission, review, and dismissal (ARD) committee in relation to the SSES program. Specifically, the change removes the requirement that an ARD committee determine whether a student has been awarded an SSES account.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began January 20, 2023, and ended February 21, 2023. Additionally, public hearings to solicit testimony and input on the proposal were held January 24 and 26, 2023. Following is a summary of public comments received and agency responses.

Comment: The Texas Council of Administrators of Special Education (TCASE) commented that the proposed rule went beyond what statute requires in relation to ARD committee meetings. TCASE suggested that subsection (i) be reworded to remove the ARD committee's responsibility to determine if a student has been awarded an SSES account. TCASE further suggested that the rule include a provision that TEA will notify school districts of students who have been awarded accounts.

Response: The agency agrees in part. Determining whether a student has been awarded an SSES account would assist an ARD committee in knowing in how much detail to provide regarding the SSES program. However, the agency has modified subsection (i) at adoption to specify that the ARD committee responsibilities are to provide information about the types of goods and services that are available and instructions and resources on accessing the online accounts. The requirement that school districts and charter schools notify families of their eligibility remains. Regarding TCASE's suggestion that the agency notify school districts of students who have been awarded accounts, the agency disagrees. The agency is unable to provide student-level information on who has accessed SSES accounts to ARD committees due to limitations of the agency's data systems.

Comment: Disability Rights Texas expressed that the phrasing "as necessary" when referring to the prioritization of SSES grants to those who qualify for the National School Lunch Program should be deleted to clearly signal that the SSES grant awards are prioritized for students with disabilities with limited financial means.

Response: The agency agrees. While the phrase "as necessary" was originally proposed to refer to the number of pending applications when a new infusion of funding was made available, the agency does have systems in place to consistently prioritize the awarding of accounts to those who qualify for the National School Lunch Program. The agency has, therefore, modified subsection (c)(3) at adoption to remove the phrase "as necessary."

Comment: TCASE commented that SSES program awards should be prioritized for those with the greatest need, that it is unclear how the agency prioritizes student awards, that using PEIMS results in an automated process for awarding accounts, and that the agency should create application periods and roll over un-awarded accounts to the next application period.

Response: The agency disagrees in part and provides the following clarification. TEC, §29.044(b), requires the prioritization of those students for whom a school district or open-enrollment charter school receives the compensatory education allotment under TEC, §48.104. The rule defines this priority as those who are eligible for the National School Lunch Program. To alleviate confusion and respond to other public comment, the agency has agreed to modify subsection (c)(3) at adoption to delete the proposed phrase "as necessary." The agency utilizes PEIMS data to verify both special education eligibility and National School Lunch Program eligibility. At this time, application periods are not utilized, as it is not expressly stated in statute that the agency has the authority to do so.

STATUTORY AUTHORITY. The amendment is adopted under Texas Education Code (TEC), §29.041, which establishes requirements for providing a supplemental special education services (SSES) and instructional materials program for certain public school students receiving special education services and requires the commissioner by rule to determine, in accordance with TEC, Chapter 29, Subchapter A-1, the criteria for providing a program to provide supplemental special education services and instructional materials for eligible public school students; TEC, §29.042, which requires the commissioner to determine requirements related to the establishment and administration of the SSES program; TEC, §29.043, which requires the commissioner to establish an application process for the SSES program; TEC, §29.044, which requires the commissioner to determine eligibility criteria for the approval of an application submitted under TEC, §29.043; TEC, §29.045, which requires the commissioner to determine requirements for students meeting eligibility criteria and requirements for assigning and maintaining accounts under TEC, §29.042(b); TEC, §29.046, which requires the commissioner to determine requirements and restrictions related to account use for accounts assigned to students under TEC, §29.045; TEC, §29.047, which requires the commissioner to determine requirements related to criteria and application for agency-approved providers and vendors; TEC, §29.048, which requires the commissioner to determine responsibilities for the admission, review, and dismissal committee; and TEC, §29.049, which requires that the commissioner adopt rules as necessary to establish and administer the SSES and instructional materials program.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §§29.041-29.049.

§102.1601. Supplemental Special Education Services and Instructional Materials Program for Certain Public School Students Receiving Special Education Services.

(a) Definitions. For the purposes of this section, the following definitions apply.

(1) Eligible student--A student who meets all program eligibility criteria under Texas Education Code (TEC), §29.044, and this section.

(2) Management system--The online system provided by the marketplace vendor to allow for account creation, management of funds, and access to the marketplace.

(3) Marketplace--The virtual platform where parents and guardians with Supplemental Special Education Services (SSES) program funds may purchase goods and services.

(4) Marketplace vendor--The vendor chosen by the Texas Education Agency (TEA) to create an online marketplace for the use of SSES program funds.

(5) Supplemental special education instructional materials--This term has the meaning defined in TEC, §29.041, and specifically excludes materials that are provided as compensatory services or as a means of providing a student with a free appropriate public education.

(6) Supplemental special education services--This term has the meaning defined in TEC, §29.041, and specifically excludes services that are provided as compensatory services or as a means of providing a student with a free appropriate public education.

(b) Eligibility criteria. All students currently enrolled in a Texas public school district or open-enrollment charter school who are served in a special education program during the 2021-2022 or 2022-2023 school year, including, but not limited to, students in early childhood special education, prekindergarten, Kindergarten-Grade 12, and 18-and-over transition programs, are eligible for the SSES program with the following exclusions:

(1) students who do not reside in Texas or move out of the state, not including military-connected students entitled to enroll or remain enrolled while outside the state; or

(2) students who previously received an SSES grant.

(c) Awards.

(1) Parents and guardians of eligible students may receive grants as long as funds are available of up to $1,500 in state funds and may receive additional federal funds, depending on eligibility and availability, for use in the purchasing of supplemental special education instructional materials and supplemental special education services through the curated marketplace of educational goods and services. Parents and guardians may receive only one grant for each eligible student. Students enrolled in a school district or open-enrollment charter school that is eligible for a compensatory education allotment under TEC, §48.104, will be prioritized to receive a grant award.

(2) TEA will use Public Education Information Management System (PEIMS) codes to verify eligibility in order to award accounts for the SSES program.

(3) TEA will prioritize the awarding of applicant accounts based on applicants qualifying for the National School Lunch Program and available funds.

(d) Establishment of the marketplace.

(1) In accordance with TEC, §29.042(d), TEA shall award an education service center (ESC) with an operational and school district support grant, which may include, but is not limited to, the following operational requirements:

(A) writing and administering a contract for a vendor for the SSES marketplace that curates the content in its marketplace for educational relevancy. In accordance with the Family Educational Rights and Privacy Act, the contract must require the vendor for the marketplace to protect and keep confidential students' personally identifiable information, which may not be sold or monetized;

(B) providing technical assistance to parents and guardians throughout the SSES program process;

(C) serving as the main point of contact for the selected marketplace vendor to ensure eligible student accounts are appropriately spent down;

(D) approving or denying all purchases from the SSES marketplace, including communication with parents and guardians about purchase order requests;

(E) increasing the number of qualified service providers in the marketplace; and

(F) approving or denying all potential service providers.

(2) Providers of supplemental special education instructional materials and services may apply to be listed in the marketplace. To become an approved marketplace service provider, an applicant must sign a service provider agreement and comply with licensing, safety, and employee background checks.

(A) Organization service providers are required to provide their Texas Tax ID for TEA to verify the validity of the organization.

(B) Individual service providers are required to provide proof of credentials and licensing in accordance with the individual service provider categories established by TEA.

(3) TEA shall provide a process for the application and approval of vendors to the marketplace.

(4) TEA and the marketplace vendor shall provide a curated list of vendors through which parents and guardians can purchase educationally relevant supplemental special education instructional materials. The established marketplace vendor shall be responsible for ensuring the vendors comply with SSES program parameters as they relate to the marketplace and be responsible for all communications with marketplace vendors.

(e) Application process for grant on behalf of a student.

(1) TEA is responsible for the application process and the determination of which applicants are approved for SSES program grants.

(2) Parents and guardians who would like to apply on behalf of their eligible students must complete the online application.

(3) Upon approval of the application:

(A) TEA shall send contact information for parents and guardians of eligible students in a secure manner to the online marketplace vendor for account creation and distribution;

(B) parents and guardians of eligible students will receive an email to the same email address provided during application from the marketplace vendor with information on how to access their accounts; and

(C) parents and guardians will be awarded an account of up to $1,500 in state funds and may be awarded in the account additional federal funds, depending on eligibility and availability, per eligible student to be used to purchase supplemental special education services and supplemental special education instructional materials.

(4) Parents and guardians of students who are deemed not eligible or who are determined to have violated account use restrictions under subsection (h) of this section will receive notification from TEA and be provided an opportunity to appeal the denial or account use determination. TEA shall exercise its discretion to determine the validity of any such appeal.

(5) If necessary, eligible students will be placed on a waitlist and parents and guardians will be notified. Should additional funds become available, priority will be given in the order established by the waitlist and in accordance with subsection (c) of this section.

(6) TEA shall maintain confidentiality of students' personally identifiable information in accordance with the Family Educational Rights and Privacy Act and, to the extent applicable, the Health Insurance Portability and Accountability Act.

(f) Approval of application; assignment of account.

(1) TEA shall set aside funds for a pre-determined number of accounts of up to $1,500 in state funds with additional federal funds set aside, depending on eligibility and availability, per account to be awarded to parents and guardians of eligible students.

(2) Parents and guardians with more than one eligible student may apply and receive a grant for each eligible student.

(3) Approved parents and guardians will receive an award notification email from the marketplace vendor and may begin spending account funds upon completion of account setup.

(4) Parents and guardians who receive an award notification but whose student no longer qualifies under subsection (b) of this section shall notify TEA of their student's change in eligibility status.

(5) Within 30 calendar days from receiving an award notification email, parents and guardians must:

(A) access or log in to their account or the account may be subject to reclamation; and

(B) agree to and sign the SSES parental acknowledgement affidavit.

(g) Use of funds. Use of SSES program funds provided to parents and guardians are limited as follows.

(1) Only supplemental special education instructional materials and supplemental special education services available through the marketplace of approved providers and vendors may be purchased with SSES program funds.

(2) Supplemental special education instructional materials and services must directly benefit the eligible student's educational needs.

(3) Supplemental special education instructional materials shall be used in compliance with TEA purchasing guidelines.

(4) If TEA approves vendors for a category of instructional material under subsection (d) of this section, supplemental special education instructional materials must be purchased from the TEA-approved vendor for that category of supplemental special education instructional material. If TEA does not establish criteria for a category of supplemental special education instructional materials, funds in a student's account may be used to purchase the supplemental special education instructional materials from any vendor.

(5) The contracted ESC has full authority to reject or deny any purchase.

(6) Parents and guardians may not use SSES program funds for reimbursement of goods or services obtained outside of the marketplace. SSES program funds shall not be paid directly to parents or guardians of eligible students.

(h) Account use restrictions. TEA may, subject to the appeal process referenced in subsection (e)(4) of this section, close or suspend accounts and reclaim a portion or all of the funds from accounts in the marketplace if:

(1) the supplemental special education materials or services that parents or guardians attempt to purchase are not educational in nature or are deemed to be in violation of the purchasing guidelines set forth by TEA;

(2) it is determined that the supplemental special education materials or services purchased do not meet the definitions in subsection (a)(5) and (6) of this section;

(3) the SSES program parental acknowledgement affidavit is not signed within 30 calendar days of receipt of account email from the marketplace vendor; or

(4) a student no longer meets the eligibility criteria set out in subsection (b) of this section.

(i) Requirements to provide information. School districts and open-enrollment charter schools shall notify families of their eligibility for the SSES program and shall provide the following at the student's admission, review, and dismissal (ARD) committee meeting:

(1) instructions and resources on accessing the online accounts; and

(2) information about the types of goods and services that are available through the SSES grant.

(j) Restrictions. A student's ARD committee may not consider a student's current or anticipated eligibility for any supplemental special education instructional materials or services that may be provided under this section when developing or revising a student's individualized education program, when determining a student's educational setting, or in the provision of a free appropriate public education.

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 March 29, 2023.

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Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: April 18, 2023
Proposal publication date: January 20, 2023
For further information, please call: (512) 475-1497

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE JUSTICE DEPARTMENT

CHAPTER 341. GENERAL STANDARDS FOR JUVENILE PROBATION DEPARTMENTS SUBCHAPTER B. JUVENILE BOARD RESPONSIBILITIES

37 TAC §341.200

The Texas Juvenile Justice Department (TJJD) adopts amendments to Texas Administrative Code Chapter 341, Subchapter B, §341.200 without changes to the proposed text as published in the October 28, 2022, issue of the *Texas Register* (47 TexReg 7237). The amended section will not be republished.

SUMMARY OF CHANGES

The amendments to §341.200, concerning Administration, remove the requirements for the juvenile board chair or a designee to serve as representative to the interagency dispute resolution process for community resource coordination groups.

PUBLIC COMMENTS

TJJD received public comments from two organizations, Disability Rights Texas and the Texas Council for Developmental Disabilities.

Comment 1: The section should add a reference to the Texas Protection and Advocacy System in a public area in addition to the posting of the other complaint procedures.

TJJD Response: While the Texas Protection and Advocacy System is a necessary part of addressing youth and parent concerns, it is outside the purview of the particular standard being addressed in this section. This section is designed to ensure parents and families know how to file concerns directly with the local juvenile probation department and juvenile board as well as know the types of issues that TJJD may get involved in as compared to those that are a purely local matter. In the future, TJJD will evaluate options to ensure probation departments are able to provide information on the Texas Protection and Advocacy System in a public area.

Comment 2: Regarding subsection (e)(4), concerning research studies, the section should require that the policies of the authorizing juvenile board include a requirement for consent by the individual or the individual's legally authorized representative.

TJJD Response: TJJD standards prohibit certain types of research studies and provide that other types may be conducted as long as they are done in compliance with TJJD standards. TJJD standards require the juvenile board to establish policies that adhere to all federal requirements governing human subjects and confidentiality. 37 TAC §341.200(e)(2)(B)(iii). TJJD believes this addresses the consent requirement.

STATUTORY AUTHORITY

The amended section is adopted under §221.002(a)(1), Human Resources Code, which requires the TJJD Board to adopt minimum standards for personnel, staffing, caseloads, programs, facilities, record keeping, equipment, and other aspects of the operation of a juvenile board that are necessary to provide adequate and effective probation services.

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

No other statute, code, or article is affected by this adoption.

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

Filed with the Office of the Secretary of State on March 30, 2023.

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Christian von Wupperfeld
General Counsel
Texas Juvenile Justice Department
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Proposal publication date: October 28, 2022
For further information, please call: (512) 490-7278

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CHAPTER 344. EMPLOYMENT, CERTIFICATION, AND TRAINING SUBCHAPTER E. TRAINING AND CONTINUING EDUCATION

37 TAC §344.670

The Texas Juvenile Justice Department (TJJD) adopts amendments to Texas Administrative Code Chapter 344, Subchapter E, §344.670 without changes to the proposed text as published in the October 28, 2022, issue of the *Texas Register* (47 TexReg 7238). The amended section will not be republished.

SUMMARY OF CHANGES

The amendments to §344.670, concerning Training Methods and Limitations, add that credit for a training topic may be granted one additional time beyond what would normally be allowed in a certification period if the topic is one of the mandatory topics required during each certification period (as listed in §344.640) and hours for the topic have been carried over from the prior certification period.

The amendments to §344.670 also add a definition of *live training* and specifying that there is no limit on the number of creditable hours that may be obtained from this type of training. Online training in which the presenter and attendees can interact are included in this category and are not subject to a limit.

The amendments to §344.670 also add that: 1) there will no longer be a limit on the number of hours obtained from pre-recorded training if the training is provided, sponsored, or co-sponsored by TJJD; and 2) the 20-hour and 10-hour limits on pre-recorded training (for juvenile supervision/probation officers and community activities officers, respectively) apply only to training that is not provided, sponsored, or co-sponsored by TJJD.

PUBLIC COMMENTS

TJJD received a public comment from Disability Rights Texas.

Comment: The section should mandate that the training be competency based, meaning that the participants are expected to demonstrate their mastery of the information provided in the training.

Response: TJJD has multi-faceted training requirements for the officers it certifies. There are specific training topics covered and then an exam on those topics is given. Passing that exam is a requirement to be certified. There is additional training required for initial certification. There are then additional training hours that must be completed every two years to maintain certification. There are requirements in standards that must be met for credit for this training to be given. 37 TAC §344.660 and §344.670. TJJD believes these requirements are sufficient and that they are consistent with the continuing education requirements for other licensed occupations.

STATUTORY AUTHORITY

The amended section is adopted under §221.002(a)(3), Human Resources Code, which requires the TJJD Board to adopt appropriate educational, preservice and in-service training, and certification standards for probation and detention officers or court-supervised community-based program personnel.

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

No other statute, code, or article is affected by this adoption.

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

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Christian von Wupperfeld
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PART 13. TEXAS COMMISSION ON FIRE PROTECTION

CHAPTER 427. TRAINING FACILITY CERTIFICATION

The Texas Commission on Fire Protection (commission) adopts amendments to 37 Texas Administrative Code Chapter 427, Training Facility Certification, §427.5, Apparatus, §427.7, Protective Clothing, Use, Care & Maintenance, §427.9, Equipment, §427.13, Records, §427.18, Live Fire Training Evolutions, §427.203, Facilities, §427.205, Apparatus, §427.207, Protective Clothing, Use, Care & Maintenance, §427.209, Equipment, §427.211, Reference Material, §427.213, Records, §427.218, Live Fire Training Evaluations, §427.219, General Information, §427.303, Training Approval Process for On-site and Distance Training Providers, §427.305, Procedures for Testing Conducted by On-site and Distance Training Providers, §427.307, On-site and Distance Training Provider Staff Requirements, §427.401, General Provisions for Training Facilities Not Owned by the State of Texas or Operated by a Public Subdivision of the State of Texas, and repeals §427.203, Records and §427.209, General Information. Amendments to §§427.5, 427.211, 427.219 and 427.401 and the repeal of §§427.203 and 427.209 are adopted without changes to the text as published in the October 7, 2022, issue of the *Texas Register* (47 TexReg 6566). These rules will not be republished. Section 427.13, Records and §427.213, Records are adopted with changes to the text as published in the October 7, 2022, issue of the *Texas Register* (47 TexReg 6566). These rules will be republished. Changes were made from the original publication to include "print or electronic" records in §427.13 and §427.213 to further define the types of records to be maintained. Further grammatical changes were made to §§427.7, 427.9, 427.18, 427.205, 427.207, 427.209, 427.218, and, 427.303. These rules will also be republished.

These adopted rules and repeals were initiated as a result of the agency's four-year rule review. The amendments reflect that the Commission regulates training facilities and the requirements for fire fighter certification training.

No comments were received from the public regarding the adoption of the amendments.

SUBCHAPTER A. ON-SITE CERTIFIED TRAINING PROVIDER

37 TAC §§427.5, 427.7, 427.9, 427.13, 427.18

The rule is adopted under Texas Government Code §419.008, which authorizes the commission to adopt or amend rules to perform the duties assigned to the commission. The rule is also adopted under Texas Government Code §419.032, which

authorizes the commission to adopt rules establishing the requirements for certification; and §419.0325, which authorizes the commission to obtain the criminal history record information for the individual seeking certification by the commission.

§427.7. Protective Clothing, Use, Care and Maintenance.

All protective clothing used during instruction for a commission approved fire protection personnel training program shall be appropriate for the training evolution. Protective clothing and elements no longer used for emergency operations may be used for non-live fire training provided such clothing and elements are not contaminated, defective, or damaged and are appropriately marked to be easily recognized.

(1) All protective clothing used for live fire training, shall comply with the minimum standards of the National Fire Protection Association (NFPA) Standard or its successor suitable for the tasks the individual is expected to perform.

(A) A certified training facility that provides personal protective equipment (PPE) shall comply with NFPA 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protection Ensembles or its successor and provide upon request a written Standard Operating Procedure (SOP) on the use, maintenance, and care of personal protective equipment (PPE)to include the application of Preliminary Exposure Reduction for determination of the appropriate level of cleaning and inspection of PPE at the conclusion of a training evolution.

(B) A certified training facility shall verify NFPA 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protection Ensembles or its successor for compliance with personal protective equipment provided by the participant.

(2) The training facility shall comply with the following guidelines for use, care and maintenance of PPE used during live-fire training depending on the type of burn facility and/or fuel used.

(A) Acquired Structures--Firefighting ensemble and/or element that has been used in an environment created by an acquired structure should be treated as stated in §435.1(a)(3) of this title (relating to Protective Clothing).

(B) Gas-Fired Training Center Buildings--Firefighting ensemble and/or element that has been used in an environment that uses gas-fired props may be cleaned as needed for soil levels that are hygienically unpleasant. Advanced cleaning and inspections should be completed as stated within the training facility's SOP.

(C) Non-Gas Fired Training Center Buildings--Firefighting ensemble and/or element that has been used in an environment that uses non-gas fired props must be assessed for contamination of products of combustion. Preliminary exposure reduction should be done as soon as the training is completed for the day. Advanced cleaning and inspection should be completed as soon as practically possible.

(D) Exterior Props--Firefighting ensemble and/or element that has been used in an environment that uses gas-fired props may be cleaned as needed for soil levels that are hygienically unpleasant. Advanced cleaning and inspections should be completed as stated within the training facility's SOP's.

(E) Exterior Class B Liquid Fires--Firefighting ensemble and/or element that has been used in exterior Class B liquid fire props must be assessed for contamination of products of combustion. Preliminary exposure reduction should be done as soon as the training is completed for the day. Advanced cleaning and inspection should be completed as soon as practically possible.

§427.9. Equipment.

The training facility must ensure that all equipment necessary for practice of performance skills identified in the commission's Curriculum Manual or Curriculum Skills Manual is available in sufficient quantity for use by trainees. The minimum equipment required for conducting training is identified in the Equipment List found in each discipline chapter within the Texas Commission on Fire Protection (TCFP) Curriculum Manual.

(1) All Self-Contained Breathing Apparatus (SCBA) that will be used during the course of instruction for a commission approved fire protection personnel training program shall comply with §435.3 of this title (relating to Self-Contained Breathing Apparatus). This rule applies whether the SCBA is provided by the academy or the trainee. If instruction in the use of self-contained breathing apparatus is a part of the training, then self-contained breathing apparatus in sufficient numbers shall be provided to enable each trainee to wear the equipment for at least the life of one breathing air tank during the training. If a trainee will be subjected to a hazardous atmosphere or where the atmosphere is unknown, the trainee shall be provided with a self-contained breathing apparatus. (Note: All self-contained breathing apparatus used by a certified training facility and the air used in self-contained breathing apparatus must comply with §435.3 of this title (relating to Self-Contained Breathing Apparatus). This rule applies whether the self-contained breathing apparatus is provided by the academy or the trainee. All students, instructors, safety personnel, and other personnel participating in any evolution or operation of fire suppression during the live fire training shall breathe from an SCBA air supply whenever operating under one or more of the following conditions:

(A) in any atmosphere that is oxygen deficient or contaminated by products of combustion, or both;

(B) in any atmosphere that is suspected of being oxygen deficient or contaminated by products of combustion, or both;

(C) in any atmosphere that can become oxygen deficient or contaminated, or both; and/or

(D) below ground level;

(2) standard classroom equipment to include appropriate instructional aids and the use of cutaways, models, flip charts, and other visual aids are recommended to enhance effectiveness of the instruction; and

(3) other equipment, which may include training simulators, training aids, clothing and tools required by the applicable training program.

§427.13. Records.

(a) Training records, print or electronic, shall be maintained by the regulated training entity that reflect at minimum:

(1) training subject;

(2) date(s) of instruction;

(3) who attended the training;

(4) instructor(s);

(5) course grade report with individual trainee test scores,

(6) individual trainee Commission-Designated Performance Skill Evaluations; and

(7) when administering distance skill evaluations, letter(s) of assurance for performance skill evaluations including the identification of the examinee, evaluating field examiner, and observer.

(b) The regulated training entity must be able to substantiate the evaluation process used to determine the trainee has acquired the

knowledge and skills to achieve the minimum level of competency required by the applicable commission curriculum and/or National Fire Protection Association (NFPA) standards.

(c) All records must be maintained by the regulated training entity for commission review for a minimum of three years or in accordance with the requirement of the Texas State Library and Archives Commission, State and Local Records Management Division, whichever is greater.

§427.18. Live Fire Training Evolutions.

The most current edition of NFPA 1403, Standard on Live Fire Training Evolutions or its successor, shall be used as a guide when developing standard operating procedures for conducting live fire training.

(1) Prior to being permitted to participate in live fire training evolutions for basic fire suppression certification training, the student shall have received training to meet the performance requirements for Fire Fighter I in NFPA 1001, Standard for Fire Fighter Professional Qualifications or its successor, related to the following subjects:

(A) safety;

(B) fire behavior;

(C) portable extinguishers;

(D) personal protective equipment to include SCBA;

(E) ladders;

(F) fire hose, appliances, and streams;

(G) overhaul;

(H) water supply;

(I) ventilation;

(J) forcible entry; and

(K) building construction.

(2) The on-site lead instructor will ensure that the water supply rate and duration for each live fire training evolution is adequate to control and extinguish the training fire. The lead instructor will also ensure that the resources necessary for backup lines to protect personnel and exposed property are available and deployed.

(3) The on-site lead instructor will ensure that the buildings or props being utilized for live fire training are in a condition that would not pose an undue safety risk.

(4) A safety officer shall be appointed for all live fire training evolutions. The safety officer shall have the authority, regardless of rank, to intervene and control any aspect of the operations when, in his or her judgment, a potential or actual danger, accident, or unsafe condition exists. The safety officer shall not be assigned other duties that interfere with safety responsibilities. The safety officer shall not be a student.

(5) No person(s) shall play the role of a victim inside the building.

(6) The participating student-to-instructor ratio shall not be greater than five to one.

(7) Prior to the ignition of any fire, instructors shall ensure that all personal protective clothing and/or self-contained breathing apparatus are NFPA compliant and being worn in the proper manner.

(8) Prior to conducting any live fire training, a pre-burn briefing session shall be conducted. All participants shall be required to conduct a walk-through of the structure in order to have a knowledge of, and familiarity with, the layout of the building and to be able to facilitate any necessary evacuation of the building.

(9) A standard operating procedure shall be developed and utilized for live fire training evolutions. The standard operating procedure shall include, but not be limited to:

(A) a Personal Alert Safety System (PASS). A PASS device shall be provided for each student and instructors participating in live fire training and shall meet the requirements in §435.9 of this title (relating to PASS devices). This applies whether the PASS device is provided by the academy or the trainee;

(B) a Personnel Accountability System that complies with §435.13 of this title (relating to Personnel Accountability System);

(C) an Incident Management System;

(D) use of personal protective clothing and self-contained breathing apparatus;

(E) an evacuation signal and procedure; and pre-burn, burn and post-burn procedures.

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

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Mike Wisko
Agency Chief
Texas Commission on Fire Protection
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SUBCHAPTER B. DISTANCE TRAINING PROVIDER

37 TAC §427.203. §427.209

Government Code §419.032, which authorizes the commission to adopt rules establishing the requirements for certification; and §419.0325, which authorizes the commission to obtain the criminal history record information for the individual seeking certification by the commission.

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

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37 TAC §§427.203, 427.205, 427.207, 427.209, 427.211, 427.213, 427.218, 427.219

Government Code §419.032, which authorizes the commission to adopt rules establishing the requirements for certification; and §419.0325, which authorizes the commission to obtain the criminal history record information for the individual seeking certification by the commission.

§427.205. Apparatus.

The following minimum apparatus resources, applicable to the discipline, are required for a distance training provider.

(1) For a certified distance training provider--approved for basic structure fire protection personnel certification training:

(A) A pumper apparatus fully equipped for functions as required by the basic fire suppression curriculum.

(B) An aerial ladder truck for functions as required by the basic fire suppression curriculum.

(2) For a certified distance training provider--approved for basic aircraft rescue fire fighting (ARFF) personnel certification training:

(A) an ARFF vehicle for assigned aircraft type and size,

(B) an ARFF vehicle with 260 gpm minimum turret; and

(C) Support vehicles per AHJ.

(3) For a certified distance training provider--approved for Driver/Operator certification training:

(A) Driver/Operator-Pumper--A fire apparatus with a permanently mounted fire pump that has a rated discharge capacity of 750 gpm (2850 L/min) or greater as defined in NFPA 1901, Standard for Automotive Fire Apparatus or its successor.

(B) Driver/Operator-Aerial--A fire apparatus with a permanently mounted, power-operated elevating device such as a ladder, ladder platform, telescoping platform, or articulating platform, with an elevating water delivery system.

§427.207. Protective Clothing, Use, Care and Maintenance.

All protective clothing used during instruction for a commission approved fire protection personnel training program shall be appropriate for the training evolution. Protective clothing and elements no longer used for emergency operations may be used for non-live fire training provided such clothing and elements are not contaminated, defective, or damaged and are appropriately marked to be easily recognized.

(1) All protective clothing used for live fire training shall comply with the minimum standards of the National Fire Protection Association (NFPA) Standard suitable for the tasks the individual is expected to perform.

(A) A certified training provider that provides personal protective equipment shall comply with NFPA 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protection Ensembles or its successor and provide upon request a written Standard Operating Procedure (SOP) on the use, maintenance, and care of personal protective equipment (PPE) to include the application of Preliminary Exposure Reduction for determination of the appropriate level of cleaning and inspection of PPE at the conclusion of a training evolution.

(B) A certified training provider shall verify NFPA 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protection Ensembles or its successor, for compliance with personal protective equipment provided by the participant.

(2) The distance training provider shall comply with the following guidelines for use, care and maintenance of PPE used during live-fire training depending on the type of burn facility and/or fuel used.

(A) Acquired Structures--Firefighting ensemble and/or element that has been used in an environment created by an acquired structure should be treated as stated in §435.1(a)(3) of this title (relating to Protective Clothing).

(B) Gas-Fired Training Center Buildings--Firefighting ensemble and/or element that has been used in an environment that uses gas-fired props may be cleaned as needed for soil levels that are hygienically unpleasant. Advanced cleaning and inspections should be completed as stated within the training facility's SOP.

(C) Non-Gas Fired Training Center Buildings--Firefighting ensemble and/or element that has been used in an environment that uses non-gas fired props must be assessed for contamination of products of combustion. Preliminary exposure reduction should be done as soon as the training is completed for the day. Advanced cleaning and inspection should be completed as soon as practically possible.

(D) Exterior Props--Firefighting ensemble and/or element that has been used in an environment that uses gas-fired props may be cleaned as needed for soil levels that are hygienically unpleasant. Advanced cleaning and inspections should be completed as stated within the training facility's SOP's.

(E) Exterior Class B Liquid Fires--Firefighting ensemble and/or element that has been used in exterior Class B liquid fire props must be assessed for contamination of products of combustion. Preliminary exposure reduction should be done as soon as the training is completed for the day. Advanced cleaning and inspection should be completed as soon as practically possible.

§427.209. Equipment.

The distance training provider must ensure that all equipment necessary for practice of performance skills identified in the commission's Curriculum Manual or Curriculum Skills Manual is available in sufficient quantity for use by trainees. The minimum equipment required for conducting training is identified in the Equipment List found in each discipline chapter within the Texas Commission on Fire Protection (TCFP) Curriculum Manual. All Self-Contained Breathing Apparatus (SCBA) that will be used during the course of instruction for a commission approved fire protection personnel training program shall comply with §435.3 of this title (relating to Self-Contained Breathing Apparatus). This rule applies whether the SCBA is provided by the academy or the trainee.

(1) If instruction in the use of self-contained breathing apparatus is a part of the training, then self-contained breathing apparatus in sufficient numbers shall be provided to enable each trainee to wear the equipment for at least the life of one breathing air tank during the training. If a trainee will be subjected to a hazardous atmosphere or where the atmosphere is unknown, the trainee shall be provided with a self-contained breathing apparatus. (Note: All self-contained breathing apparatus used by a certified training facility and the air used in self-contained breathing apparatus must comply with §435.3 of this title.This rule applies whether the self-contained breathing apparatus is provided by the academy or the trainee. All students, instructors, safety personnel, and other personnel participating in any evolution or operation of fire suppression during the live fire training shall breathe from an SCBA air supply whenever operating under one or more of the following conditions:

(A) in any atmosphere that is oxygen deficient or contaminated by products of combustion, or both.

(B) in any atmosphere that is suspected of being oxygen deficient or contaminated by products of combustion, or both.

(C) in any atmosphere that can become oxygen deficient or contaminated, or both; and/or

(D) below ground level.

(2) standard classroom equipment to include appropriate instructional aids and the use of cutaways, models, flip charts, and other visual aids are recommended to enhance effectiveness of the instruction; and

(3) other equipment, which may include training simulators, training aids, clothing and tools required by the applicable training program.

§427.213. Records.

(a) Training records, print or electronic, shall be maintained by the regulated distance training provider that reflect at minimum:

(1) training subject;

(2) date(s) of instruction;

(3) who attended the training;

(4) instructor(s);

(5) course grade report with individual trainee test scores;

(6) individual trainee Commission-Designated Performance Skill Evaluations; and

(7) when administering distance skill evaluations, letter(s) of assurance for performance skill evaluations including the identification of the examinee, evaluating field examiner, and observer.

(b) The regulated distance training provider must be able to substantiate the evaluation process used to determine the trainee has acquired the knowledge and skills to achieve the minimum level of competency required by the applicable commission curriculum and/or NFPA standards.

(c) All records must be maintained by the regulated distance training provider for commission review for a minimum of three years or in accordance with the requirement of the Texas State Library and Archives Commission, State and Local Records Management Division, whichever is greater.

§427.218. Live-Fire Training Evolutions.

The most current edition of NFPA 1403, Standard on Live Fire Training Evolutions or its successor, shall be used as a guide when developing standard operating procedures for conducting live fire training.

(1) Prior to being permitted to participate in live fire training evolutions for basic fire suppression certification training, the student shall have received training to meet the performance requirements for Fire Fighter I in NFPA 1001, Standard for Fire Fighter Professional Qualifications or its successor, related to the following subjects:

(A) safety;

(B) fire behavior;

(C) portable extinguishers;

(D) personal protective equipment to include SCBA;

(E) ladders;

(F) fire hose, appliances, and streams;

(G) overhaul;

(H) water supply;

(I) ventilation;

(J) forcible entry; and

(K) building construction.

(2) The on-site lead instructor will ensure that the water supply rate and duration for each live fire training evolution is adequate to control and extinguish the training fire. The lead instructor will also ensure that the resources necessary for backup lines to protect personnel and exposed property are available and deployed.

(3) The on-site lead instructor will ensure that the buildings or props being utilized for live fire training are in a condition that would not pose an undue safety risk.

(4) A safety officer shall be appointed for all live fire training evolutions. The safety officer shall have the authority, regardless of rank, to intervene and control any aspect of the operations when, in his or her judgment, a potential or actual danger, accident, or unsafe condition exists. The safety officer shall not be assigned other duties that interfere with safety responsibilities. The safety officer shall not be a student.

(5) No person(s) shall play the role of a victim inside the building.

(6) The participating student-to-instructor ratio shall not be greater than five to one.

(7) Prior to the ignition of any fire, instructors shall ensure that all personal protective clothing and/or self-contained breathing apparatus are NFPA compliant and being worn in the proper manner.

(8) Prior to conducting any live fire training, a pre-burn briefing session shall be conducted. All participants shall be required to conduct a walk-through of the structure in order to have a knowledge of, and familiarity with, the layout of the building and to be able to facilitate any necessary evacuation of the building.

(9) A standard operating procedure shall be developed and utilized for live fire training evolutions. The standard operating procedure shall include, but not be limited to:

(A) a Personal Alert Safety System (PASS). A PASS device shall be provided for each student and instructors participating in live fire training and shall meet the requirements in §435.9 of this title (relating to PASS devices). This applies whether the PASS device is provided by the academy or the trainee,

(B) a Personnel Accountability System that complies with §435.13 of this title (relating to Personal Accountability System),

(C) an Incident Management System,

(D) use of personal protective clothing and self-contained breathing apparatus; or

(E) an evacuation signal and procedure; and pre-burn, burn and post-burn procedures.

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

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Mike Wisko
Agency Chief
Texas Commission on Fire Protection
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SUBCHAPTER C. TRAINING FACILITY CERTIFICATION

37 TAC §§427.303, 427.305, 427.307

Government Code §419.032, which authorizes the commission to adopt rules establishing the requirements for certification; and §419.0325, which authorizes the commission to obtain the criminal history record information for the individual seeking certification by the commission.

§427.303. Training Approval Process for On-Site and Distance Training Providers.

(a) When seeking training prior approvals (TPAs), a training provider shall certify that it has provided the resources described in §427.1 or §427.201 of this title as applicable (relating to Minimum Standards for Certified Training Facilities for Fire Protection Personnel and Minimum Standards for Distance Training Provider, respectively).

(b) All training for certification must be approved by the commission. A training provider must submit training prior approval information at least 10 days prior to the proposed start date of the training.

(c) Approved courses are subject to audit by commission staff at any time. Any deviation from the information submitted in the original training must be requested for approval from the commission at least one day before the change takes place unless the training provider is unable to do so because of unforeseen circumstances.

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

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SUBCHAPTER D. CERTIFIED TRAINING FACILITIES

37 TAC §427.401

Government Code §419.032, which authorizes the commission to adopt rules establishing the requirements for certification; and §419.0325, which authorizes the commission to obtain the criminal history record information for the individual seeking certification by the commission.

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PART 15. TEXAS FORENSIC SCIENCE COMMISSION

CHAPTER 651. DNA, CODIS, FORENSIC ANALYSIS, AND CRIME LABORATORIES
SUBCHAPTER A. ACCREDITATION

37 TAC §651.4

The Texas Forensic Science Commission ("Commission") adopts an amendment to 37 Texas Administrative Code §651.4 with changes to the text as published in the March 10, 2023, issue of the *Texas Register* (46 TexReg 1440). This rule will be republished.

This section is to establish a timeline for removal of its recognition of the accrediting body the American Board of Forensic Toxicology ("ABFT") in accordance with ABFT's strategic partnership with accrediting body ANSI National Accreditation Board (ANAB) whereby ANAB will be assuming ABFT's laboratory accreditation responsibilities.

Summary of Comments. No comments were received regarding the amendments to this section.

Statutory Authority. The amendment is adopted under Tex. Code Crim. Proc. art. 38.01 §§ 4-d and 3-a and has been reviewed by legal counsel and found to be within the state agency's authority to adopt.

Cross reference to statute. The adoption affects Tex. Code Crim. Proc. art. 38.01 § 4-d.

§651.4. List of Recognized Accrediting Bodies.

(a) The Commission recognizes the accrediting bodies in this subsection, subject to the stated discipline or category of analysis limitations:

(1) ANSI National Accreditation Board (ANAB)--recognized for accreditation of all disciplines which are eligible for accreditation under this subchapter as well as for the administration of the American Board of Forensic Toxicology (ABFT) program.

(2) American Association for Laboratory Accreditation (A2LA)--recognized for accreditation of all disciplines which are eligible for accreditation under this chapter.

(3) American Board of Forensic Toxicology (ABFT)--recognized for accreditation of forensic toxicology discipline only. After December 31, 2022, the Commission will no longer renew laboratory accreditation for laboratories accredited solely by ABFT. Laboratories in good standing with ABFT after December 31, 2022, will maintain their existing accreditation until it expires or is otherwise suspended, revoked or withdrawn by the Commission. After this final accreditation period, the Commission will no longer recognize accreditation by

ABFT, and laboratories must obtain accreditation by an entity listed in either paragraph (1) or (2) of this subsection.

(b) If an accrediting body is recognized under subsection (a) of this section and the recognized body approves a new discipline, category of analysis or procedure, the Commission may temporarily recognize the new discipline, category of analysis or procedure. A temporary approval shall be effective for 120 days.

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

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Leigh Tomlin
Associate General Counsel
Texas Forensic Science Commission
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For further information, please call: (512) 784-0037

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37 TAC §651.5, §651.203

The Texas Forensic Science Commission ("Commission") adopts amendments to 37 Texas Administrative Code §651.5 and §651.203 without changes to the text as published in the February 2, 2023, issue of the *Texas Register* (46 TexReg 443). These rules will not be republished. The purpose of these amendments is to remove certain categories of analysis from the scope of firearms/toolmarks analysis that are subject to State accreditation and licensing requirements.

Summary of Comments. No comments were received regarding the amendments to this section.

Statutory Authority. The amendments are adopted under Tex. Code Crim. Proc. art 38.01 §§ 4-a and (3)-a.

Cross reference to statute. The adoption amends rules 37 Texas Administrative Code §651.5 and §651.203.

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

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Associate General Counsel
Texas Forensic Science Commission
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For further information, please call: (512) 936-0661

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SUBCHAPTER C. FORENSIC ANALYST LICENSING PROGRAM

37 TAC §651.222

The Texas Forensic Science Commission ("Commission") adopts amendments to 37 Texas Administrative Code §651.222 without changes to the text as published in the February 10, 2023, issue of the *Texas Register* (46 TexReg 648). The rule will not be republished.

The purpose of this amendment is to establish voluntary forensic analyst licensing programs for latent print analysts and digital forensic analysts.

Summary of Comments. No comments were received regarding the amendments to this section.

Statutory Authority. The amendment is adopted under Tex. Code Crim. Proc. art 38.01 §§ 4-d and 3-a and has been reviewed by legal counsel and found to be within the state agency's authority to adopt.

Cross reference to statute. The adoption affects Tex. Code Crim. Proc. art 38.01 §4-a(c).

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 9. CONTRACT AND GRANT MANAGEMENT

SUBCHAPTER B. CONTRACTS FOR HIGHWAY PROJECTS

43 TAC §§9.10 - 9.20, 9.23, 9.24, 9.26

The Texas Department of Transportation (department) adopts amendments to §§9.10 - 9.20, 9.23, 9.24, and 9.26 concerning contracts for highway projects. The amendments to §§9.10 - 9.20, 9.23, 9.24, and 9.26 are adopted without changes to the proposed text as published in the December 30, 2022, issue of the *Texas Register* (47 TexReg 8960) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

Amendments to Chapter 9, Subchapter B update the rules to reflect the recent amendment of Transportation Code, §223.001, as well as to align the rules with the current and updated business practices.

Transportation Code, Chapter 223 controls the department's low-bid contract letting and award process. Before 2019, §223.001 required the department to submit for competitive bids each contract for: (1) the improvement of a highway that is part of the state highway system; or (2) materials to be used in the construction or maintenance of that highway. Senate Bill 1092, 86th Legislature, Regular Session, 2019, amended §223.001 to add the procurement of traffic control and safety devices to be

used on a highway to that list. Section 233.001 was amended by Senate Bill 1270, 87th Legislature, Regular Session, 2021, to allow flexibility in the purchase of some roadway materials and traffic control or safety devices using the State Purchasing and General Services Act.

During the formal process for revising the department's *Standard Specifications for Construction and Maintenance of Highways, Streets, and Bridges* it was determined that some changes to the current edition of that publication require rule changes before they can be made in the revised edition. Those necessary changes are made in this rulemaking.

This rulemaking also makes various non-substantive editing changes throughout the subchapter to correct grammatical errors and to provide clarity and consistency within Chapter 9, Subchapter B. Generally, the non-substantive changes will not be specifically addressed in this explanation of the amendments.

Amendments to the heading of Chapter 9, Subchapter B change the heading to "Contracts for Highway Projects" to better describe the subject of the subchapter after the amendments made by this rulemaking.

Amendments to §9.10, Purpose, add a new subsection (b). This new subsection sets out the option available to the department under Transportation Code, §223.001(c) for purchasing specified types of goods under the State Purchasing and General Services Act as an alternative to using the procedure provided under Chapter 9, Subchapter B for their purchase.

Amendments to §9.11, Definitions, add, delete, and amend various definitions used in the subchapter. The amendments delete the definitions of "construction contract," which is included in the definition of highway improvement contract, and delete "available bidding capacity" and move the meaning of the term to §9.12, the section of the rules in which it substantively used.

Definitions are added for "Materials contract," "Materials Supplier's Questionnaire," and "person." Because a bidder may or may not have entered into a contract with department and therefore, be a contractor with the department, the term "contractor" is updated to "person" throughout Chapter 9, Subchapter B to make this correlation.

Amendments to §9.12, Qualification of Bidders, clarify the requirements necessary to be eligible to bid on highway improvement contracts and on materials contracts. The materials suppliers should not be required to submit financial or project work experience information for the prequalification process. The financial or project work experience information of the supplier is not relevant to its ability to sell materials; therefore, there is low risk to the department related to that experience. However, forcing a supplier to submit a confidential or bidder's questionnaire could have large implications. These suppliers do not have the experience required by the current §9.12 to receive the bidding capacities needed for materials contracts. The Confidential Questionnaire is currently the only avenue to gain a large bidding capacity, and it is determined by the audited financial records.

A questionnaire is required, however, to enter suppliers into the Contractor Bidding System (CBS) for bidding. The Materials Supplier's Questionnaire gathers information such as company contact information, signature authority, and other federal and state requirements. This form is submitted to the department's Construction Division (CST) for review and approval, and then entered in CBS and Integrated Contractor Exchange (iCX). CST maintains the list of approved materials suppliers on www.txdot.gov.

New §9.12(a)(2)(E), adds the purchase of goods as an allowable waived project due to the simplicity of that type of contract. New §9.12(a)(3) states that approved materials suppliers will only be able to bid on material type contracts by submitting a Materials Supplier's Questionnaire. Any contractor or supplier that is qualified with either a Confidential or Bidder's Questionnaire will be able to bid on these material type contracts without having their bidding capacities affected on other highway improvement contracts.

In §9.12(c), "construction or maintenance contract" is changed to "highway improvement contract" since both types of contracts are highway improvement contracts. Additionally, in §9.12(c)(1)(B), "in this state" is deleted since it is no longer a requirement for financial records to be certified by a CPA firm that practices public accountancy in Texas only.

In §9.12(e), an addition clarifies that bidding capacity does not apply to materials or building contracts and that those types of contracts do not affect a bidder's bidding capacity. An explanation of how "available bidding capacity" is determined is moved to subsection (e)(6) from the definitions section.

In §9.12(g), language is added to limit to once per year affiliated entities ability to submit documentation for review establishing their independence. The affiliation review process is a four- to five-month process that is conducted by the department's Compliance Division and that includes site visits and financial, personnel, and equipment data review). Currently, a person who is denied an exception can immediately request another review even if there has been no change to the relationship or other affiliation criteria. Limiting to once a year would provide enough time for the contractors to make the necessary changes to get the affiliation removed.

Amendments to §9.13, Notice of Letting and Issuance of Bid Forms, replace "bid" with "proposal" to be in line with the terms currently used by the department. "Highway improvement" and "construction and maintenance" are deleted since this section applies for any applicable contract. Clarification is provided that only highway improvement projects have bidding capacities. Section 9.13(e)(1)(B), which lists the reasons for the department not issuing a proposal form to a bidder, is revised to conform to department practices. New §9.13(e)(1)(C) lists the reasons that the department will not issue a proposal form for the rebid of a contract; two rebidding prohibitions listed in existing §9.13(e)(1)(B) are moved to this new paragraph. Existing subsection (e)(1)(C) is redesignated as subsection (e)(1)(D), accordingly.

Amendments to §9.14, Submittal of Bid, clarify that the section applies to any contract subject to this subchapter. The amendments also clarify that a computer printout may not be used to manually submit a bid. The intent of the original language of this provision was to provide that a computer printout could be used as a means to submit only a bid item insert and not as a replacement for the bid document. If the current language were misinterpreted and a bidder were to substitute a computer printout for a proposal, the bid would be thrown out. The amendments clarify that a bid guaranty can be made payable to either the Texas Transportation Commission (commission) or the department. For electronic bids, the bid guaranty must reflect either the name or vendor number of the bidder or bidders. It is easy for a bidder to write an incorrect name but less likely a series of

numbers. Adding the vendor number provides another option for bidder identification and reduces the chance of a bid not being accepted.

Amendments to §9.15, Acceptance, Rejection, and Reading of Bids, provide that all bids are read but subsection (b) lists bid responses that are considered nonresponsive and will not be considered. These updates include proposals that are not signed by an authorized signer, proposals incorrectly typed not using the appropriate bid price format, the bidder not meeting required technical qualifications, the bidder failing to submit a DBE commitment, and bidder failing to participate in E-Verify system.

In §9.15(b)(3), amendments clarify that bids by affiliated bidders will not be excluded if an affiliated exception was granted by the executive director. Changes to §9.15(d), clarify that written requests for withdrawing a manually submitted bid must be submitted to the letting official.

Amendments to §9.16, Tabulation of Bids, provide that an electronically submitted bid will prevail over a manually submitted bid to determine the total bid amount. This was a request by contractors and administration since paper bids tend to have more errors and an electronic bid can be revised easier than a paper bid in the event a bidder's price changes. In §9.16(e), "commission" is changed to "department" since the department reviews and determines the bid error to make a recommendation to the commission.

Amendments to §9.17, Award of Contract, removes language stating that if the department enters into contract with the second lowest bidder, the low bidder may be considered in default. There are no damages to the department so there is no reason to declare the low bidder in default.

Amendments to §9.18, Contract Execution, Forfeiture of Bid Guaranty, and Bond Requirements, is amended to update insurance language on materials contracts to be similar to routine maintenance contracts, for which insurance is not needed until work begins. New §9.18(d), provides that materials contract providers are not required to purchase payment or performance bonds since a materials contract is not a public work contract; therefore, payment or performance bonds are not required under Government Code, §2253.021. Furthermore, in the Comptroller's Contract Management Guide, the Comptroller discourages the use of performance bonds unless there is a compelling need or statutory requirement, as a bond requirement may restrict competition, delay the award, and raise the cost of the contract.

Amendments to §9.19, Submittal of Bid, clarify when an emergency contract may be awarded. New subsection (j) provides that contractor performance evaluation requirements do not apply to emergency contracts because an emergency contract is not a low bid procured contract.

Amendments to §9.20, Partial Payments, provide that any contract entered into under Subchapter B may have partial payments.

Amendments to §9.23, Evaluation and Monitoring of Contract Performance, clarify the responsibilities for the evaluation of performance under the various types of contracts entered into under Chapter 9, Subchapter B. There is no substantive change made by the amendments to this section.

Amendments to §9.24, Evaluation and Monitoring of Contract Performance, establish the procedure under which materials contracts will be handled by the Performance Review Committee in the case of a default by the contractor.

Amendments to §9.26, Inclusion of Contract Remedies in Contracts, ensure that notice of possible contract remedies in the case of substandard performance is provided to the contractor on a materials contract.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §223.004, which authorizes the commission to adopt rules to prescribe conditions under which a bid may be rejected by the department; Transportation Code, §223.0041, which requires the commission to adopt rules awarding a maintenance contract to the second lowest bidder; Transportation Code, §223.005, which authorizes the commission to adopt certain rules relating to bids on contracts of less than $300,000; Transportation Code, §223.012, which requires the commission to adopt rules relating to contractor performance; and Transportation Code, 223.014, which requires the commission to adopt rules relating to a bid guaranty.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 223, Subchapter A.

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 March 31, 2023.

TRD-202301250
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Effective date: April 20, 2023
Proposal publication date: December 30, 2022
For further information, please call: (512) 463-8630

CHAPTER 23. TRAVEL INFORMATION
SUBCHAPTER E. SUBSCRIBER AND PURCHASER INFORMATION

43 TAC §§23.81 - 23.85

The Texas Department of Transportation (department) adopts the repeal of §§23.81 - 23.85 concerning Subscriber and Purchaser Information. The repeal of §§23.81 - 23.85 is adopted without changes to the proposed text as published in the December 30, 2022, issue of the *Texas Register* (47 TexReg 8974) and will not be republished.

EXPLANATION OF ADOPTED REPEALS

Senate Bill No. 15, 87th Legislature, Regular Session, banned the disclosure of information regarding Texas Highways subscribers and other promotional product purchasers. With this prohibition, §§23.81 - 23.85 concerning the use of subscriber and purchaser Information are no longer necessary. Repeal of

these sections would remove all regulations concerning permissible disclosure of subscriber and purchaser information.

COMMENTS

No comments on the proposed repeal were received.

STATUTORY AUTHORITY

The repeal is adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapter 204

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 March 31, 2023.

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Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Effective date: April 20, 2023
Proposal publication date: December 30, 2022
For further information, please call: (512) 463-8630

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CHAPTER 28. OVERSIZE AND OVERWEIGHT VEHICLES AND LOADS

SUBCHAPTER J. PORT OF PALACIOS PERMITS

43 TAC §§28.120 - 28.127

The Texas Department of Transportation (department) adopts new §§28.120 - 28.127, concerning Port of Palacios Authority Permits. The new §§28.120 - 28.127 are adopted without changes to the proposed text as published in the December 30, 2022, issue of the *Texas Register* (47 TexReg 8975) and will not be republished.

EXPLANATION OF ADOPTED NEW SECTIONS

Under Transportation Code, Chapter 623, Subchapter K, the Texas Transportation Commission (commission) has the authority to authorize Port of Palacios Authority (Authority) to issue permits for oversize and overweight vehicles on certain roads within the Authority. The Authority contacted the department and expressed the desire to obtain the authority needed to issue permits as allowed under current state law. The proposed new sections are necessary to authorize the Authority to issue permits and to implement and carry out the provisions of Transportation Code, Chapter 623, Subchapter K. These rules add to Chapter 28 of the department's rules new Subchapter J which was developed to be consistent with similar optional permitting programs previously established by the commission.

New §28.120, Purpose, sets out the purpose of Subchapter J, which is to allow the Authority to issue permits for the movement of oversize or overweight vehicles weighing up to 125,000 pounds on roads designated by Transportation Code, §623.219(b-1).

New §28.121, Definition, defines the Port of Palacios as the "Authority."

New §28.122, Authority's Powers and Duties, provides the powers and duties of the Authority and the department for the implementation and oversight of the Authority's permit program. Subsection (a) authorizes the issuance of permits and collection of fees and provides the maximum dimensions and gross weight that may be allowed under a permit. Subsection (b) authorizes the department to require a surety bond to pay for the costs of the maintenance of the roadways that are used by the permitted vehicles if the amount of the fees deposited in the state highway fund is not sufficient to cover those costs. The Authority can prevent recovery on the bond by paying the amount not covered by the fees. This section also covers the verification of permits, the provision of training necessary for the Authority to issue permits, accounting and auditing requirements, and audits. Subsection (g) provides the department's authority to ensure that the Authority complies with applicable law, including the rules in new Subchapter J. Subsection (h) sets out the fee requirements. Subsection (i) requires the Authority to enter into a contract with the department for the maintenance of roads on which the permitted vehicles will travel. Finally, subsection (j) sets out the Authority's reporting requirements. The provisions of the section were developed to be in compliance with Transportation Code, Chapter 623, Subchapter K, and to be consistent with similar optional permitting programs previously established.

New §28.123, Permit Eligibility, establishes the eligibility requirements that must be satisfied for the issuance of a permit by the Authority. The section prohibits the Authority from issuing a permit to a person or for a vehicle if administrative penalties imposed under Transportation Code, §623.271 have not been paid. This prohibition is required under Transportation Code, §623.271.

New §28.124, Permit Issuance Requirements and Procedures, sets out the requirements related to the form and content of the application for a permit. The requirements are necessary to comply with Transportation Code, §623.215 and are as consistent as possible with similar optional permitting programs previously established by the department.

New §28.125, Permit Weight Limits for Axles, provides the permit weight limits for axles that the Authority must follow as part of the permit program. Requirements and specifications include minimum axle group spacing and maximum permit weight for single and multiple axles.

New §28.126, Movement Requirements and Restrictions, sets forth movement requirements and restrictions that the Authority and a permittee must follow as part of the permit program. A permittee is required to carry the issued permit when moving the permitted vehicle and is prohibited under this section from moving an oversize or overweight load if a permit becomes void. A permit is void on issuance if the applicant for the permit gives false or incorrect information and becomes void when the permittee fails to comply with the restrictions or conditions stated in the permit or when the permittee changes or alters the information in the permit. The section provides limitations on the movement of a permitted vehicle because of weather conditions, road work, or time of day. Finally, the section sets out the requirements for types of scales that may be used to weigh permitted vehicles and provides speed restrictions.

New §28.127, Records, provides the records maintenance requirements that the Authority must follow as part of the permit process to ensure the department has adequate access to oversee the program.

COMMENTS

No comments on the proposed new sections were received.

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §623.212, which allows the commission to authorize the authority to issue permits for the movement of oversize or overweight vehicles, and Transportation Code, §623.002, which provides the commission with the authority to establish rules necessary to implement Transportation Code, Chapter 623.

CROSS REFERENCE TO STATUTE

Transportation Code, Chapter 623, Subchapter K.

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 March 31, 2023.

TRD-202301252
Becky Blewett
Deputy General Counsel
Texas Department of Transportation
Effective date: April 20, 2023
Proposal publication date: December 30, 2022
For further information, please call: (512) 463-8630

Review Of Agency Rules

This section contains notices of state agency rule review as directed by the Texas Government Code, §2001.039. Included here are proposed rule review notices, which invite public comment to specified rules under review; and adopted rule review notices, which summarize public comment received as part of the review. The complete text of an agency's rule being reviewed is available in the *Texas Administrative Code* on the Texas Secretary of State's website.

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the website and printed copies of these notices may be directed to the *Texas Register* office.

Proposed Rule Reviews

Texas Alcoholic Beverage Commission

Title 16, Part 3

Pursuant to Texas Government Code §2001.039, the Texas Alcoholic Beverage Commission (TABC) will review 16 TAC §§50.1, 50.3 - 50.5, 50.8, 50.12 - 50.20, 50.23, and 50.26 - 50.33, relating to Alcoholic Beverage Seller Server and Delivery Driver Training. TABC will consider whether the reasons for initially adopting these rules continue to exist and determine whether these rules should be repealed, readopted, or readopted with amendments. Simultaneous with this rule review, TABC separately proposed amendments to rules 16 TAC §§50.4, 50.15, 50.17, 50.19, 50.20, 50.23, and 50.31. That proposal is also in this edition of the *Texas Register.*

TABC will consider any written comments on the rule review that are received by TABC no later than 5:00 p.m., central time, on May 14, 2023. Send your comments to rules@tabc.texas.gov or to the Office of General Counsel, Texas Alcoholic Beverage Commission, P.O. Box 13127, Austin, Texas 78711-3127.

TRD-202301232
James Person
General Counsel
Texas Alcoholic Beverage Commission
Filed: March 30, 2023

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Adopted Rule Reviews

Texas State Board of Plumbing Examiners

Title 22, Part 17

The Texas State Board of Plumbing Examiners (TSBPE) filed a Notice of Intent to Review to consider for readoption, revision, or repeal the rules at Chapter 367 (Enforcement), in their entirety, under Title 22, Part 17, of the Texas Administrative Code (TAC). This review was conducted in accordance with Texas Government Code §2001.039.

The Notice of the proposed rule review was published in the July 8, 2022, issue of the *Texas Register* (47 TexReg 3987).

No comments were received in response to this notice.

Review and Recommendation

The Board reviewed each of the rules in Chapter 367 and has determined that the reasons for adopting or readopting the rules in this chapter continue to exist. The rules are still essential in implementing Chapter 1301 of the Texas Occupations Code (the Plumbing License Law or the PLL.) The rules provide details that are not found in the PLL but are necessary for implementation and operation of the program.

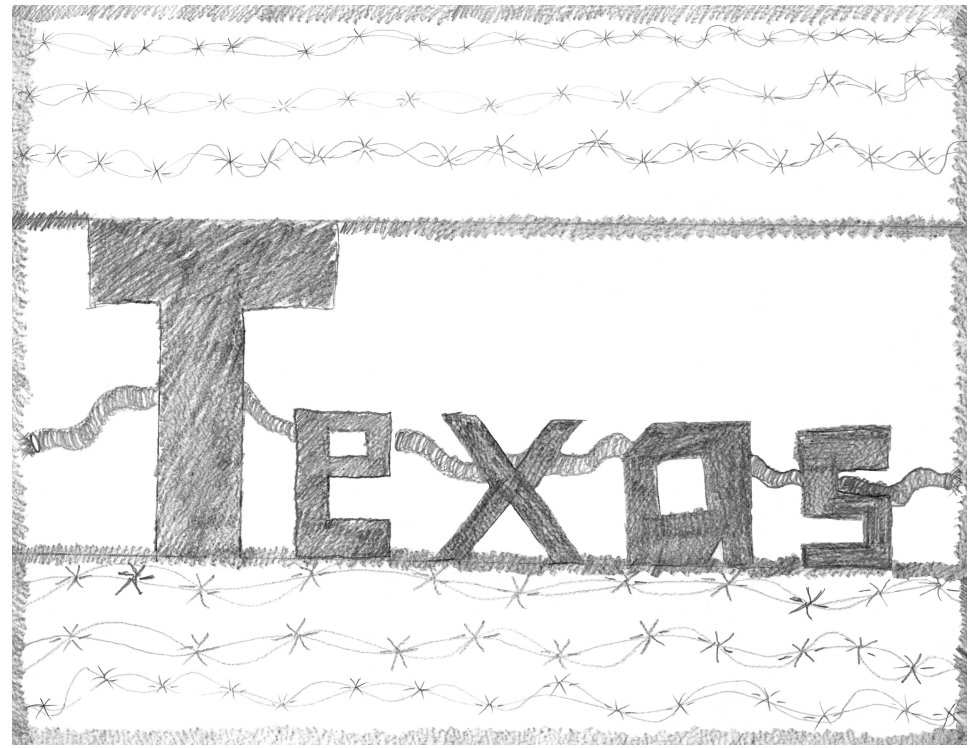
The Board may propose amendments in the future to update, clarify, or supplement the existing rules. Any proposed changes to the rules will be published in the Proposed Rules section of the *Texas Register* and will be open for public comment before final adoption by TSBPE in accordance with the requirements of the Administrative Procedure Act, Texas Government Code, Chapter 2001.

Board Action

At its meeting on March 28, 2023, the Texas State Board of Plumbing Examiners readopted 22 TAC, Part 17, Chapter 367, in its entirety and in its current form. This concludes the review of Chapter 367 in accordance with Texas Government Code §2001.039.

TRD-202301247
Lynn Latombe
General Counsel
Texas State Board of Plumbing Examiners
Filed: March 30, 2023

♦ ♦ ♦


TEXAS

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 1: 28 TAC §5.9970(b)

CONSUMER BILL OF RIGHTS

Personal Automobile Insurance

What is the Bill of Rights?

It is a basic outline of important rights you have under Texas law. Insurance companies must give you this Bill of Rights with your policy. It is important to read and understand your policy.

The Bill of Rights is not:

- A complete list of all your rights,
- Part of your policy, or
- A list of everything that you are responsible for.

Questions about these rights?

- If you are not sure about anything in your policy, ask your agent or insurance company.
- If you have questions or a complaint, contact the Texas Department of Insurance (TDI):

  Call with a question: 1-800-252-3439
  Email with a question: ConsumerProtection@tdi.texas.gov
  File a complaint through the website:
  www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html
  File a complaint by mail: Consumer Protection CO-CP
  P.O. Box 12030
  Austin, TX 78711-2030

- To learn more about insurance, visit www.opic.texas.gov or call the Office of Public Insurance Counsel (OPIC) at 1-877-611-6742.

AVISO: Este documento es un resumen de sus derechos como asegurado. Tiene derecho a llamar a su compañía de seguros y obtener una copia de estos derechos en español. Además, puede ser que su compañía de seguros tenga disponible una versión de su póliza en español.

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Where to Get Information

1. **Your insurance company.** When you get a copy of your policy you will also get an "Important Notice" from the company. The notice explains how to contact your company and how to file a complaint. You may request a complete copy of your policy from your company at any time.

2. **Your declarations page.** The declarations page, also called the "dec page," shows: (a) the name and address of your insurance company, (b) the dates your policy is in effect, (c) the insured vehicles and drivers, (d) any excluded drivers, (e) the amounts and types of coverage, and (f) your deductibles.

3. **The Texas Department of Insurance (TDI).** You have the right to call TDI for free at 1-800-252-3439 for information and help with a complaint against an insurer. You can also find information on the TDI website at www.tdi.texas.gov.

4. **Resources for shopping for insurance.** The Office of Public Insurance Counsel (OPIC) and TDI developed www.HelpInsure.com to help you compare rates and coverages for different insurance companies. OPIC also has an online tool to help you compare policies. You can find this policy comparison tool at www.opic.texas.gov.

What You Should Know When You File a Claim

5. **Choice of repair shop and replacement parts.** You have the right to choose the repair shop and parts for your vehicle. An insurance company may not specify the brand, type, kind, age, vendor, supplier, or condition of parts or products used to repair your auto, but they are not required to pay more than a reasonable amount.

6. **Auto repair notice requirements.** The insurance company must provide you a document about your rights regarding auto repairs as follows:

    - **Claims submitted by telephone:** Written notice within 3 business days or verbal notice during the call, followed by written notice within 15 business days;
    - **Claims submitted in person:** Written notice at the time you present your vehicle to an insurer, an insurance adjuster, or other person in connection with a claim for repair; or
    - **Claims submitted in writing (including email and fax):** Written notice must be provided within 3 business days of the insurance company receiving notice of the claim.

7. **Deadlines for processing claims and payments.** When you file a claim on your own policy, the insurance company must meet these deadlines:

    - **Within 15 days after you file a claim:** The company must let you know they received your claim. The company must also start their investigation and ask you for any other information they need.
    - **Within 15 business days after they get all the information they need:** The company must approve or deny your claim in writing. They can extend this deadline up to **45 days** from the date they: (a) let you know they need more time and (b) tell you why.
    - **Within 5 business days after they let you know your claim is approved**: The company must pay the claim.

    Note: TDI can extend these deadlines by 15 more days if there is a weather-related catastrophe.

If your company fails to meet these deadlines, you may be able to collect the claim amount, interest, and attorney's fees.

8. **Written explanation of claim denial.** Your insurance company must tell you in writing why your claim or part of your claim was denied.

9. **Information not required for processing your claim.** Your insurance company can only ask for information reasonably needed for their claim investigation. However, they cannot ask for your federal income tax returns unless: (a) they get a court order or (b) your claim involves a fire loss, loss of profits, or lost income.

10. **Reasonable investigation.** Your insurance company cannot refuse to pay your claim without a reasonable investigation of the claim. You should keep records of all claim communications (including notes from phone calls) and other claim documentation (including damage estimates and receipts).

11. **Deductible recovery.** If another person may be liable for the damage to your auto and you (a) filed a claim, and (b) paid or owe a deductible on your own policy, then your insurance company must:
    - Take action to recover your deductible no later than 1 year from when your claim is paid; or
    - Refund your deductible; or
    - Notify you that they will not take action and allow you to try to collect your money (a) within 1 year from that date your claim is paid, or (b) at least 90 days before the statute of limitations expires (whichever date comes first).

12. **Notice of liability claim settlement.** Liability means you are responsible for other people's injuries or damage to their property. Your insurance company must let you know in writing:
    - About the first offer to settle a claim against you within **10 days** after the offer is made.
    - About any claim settled against you within **30 days** after the date of the settlement.

Who to Contact for Claim Disagreements

13. **Claim disagreements.** You can dispute the amount of your claim payment or what is covered under your policy. You can:
    - Contact your insurance company.
    - Contact the repair person or shop.
    - Contact an attorney to advise you of your rights under the law. The State Bar of Texas can help you find an attorney.
    - Pay a qualified appraiser to examine the damage to your property.
    - File a complaint with TDI.

What You Should Know about Renewal, Cancellation, and Nonrenewal

Renewal means that your insurance company is extending your policy for another term.

Cancellation means that, **before the end of the policy period**, the insurance company:
- Terminates the policy;
- Gives you less coverage or limits your coverage; or

- Refuses to give additional coverage that you are entitled to under the policy.

"**Refusal to renew**" and "**nonrenewal**" are terms that mean your coverage ends **at the end of the policy period**. The policy period is shown on the declarations page of your policy.

14. **Offer of uninsured/underinsured motorist and personal injury protection coverages.** Insurance companies must offer you Uninsured/Underinsured Motorist (UM/UIM) and Personal Injury Protection (PIP) coverage on a new policy. If you decline them, it must be in writing. The company is not required to reoffer these coverages upon renewal, but you may request them at any time.

15. **Insurance company cancellation of personal automobile policies.** If your policy has been in effect for **60 days or more**, your company can only cancel your policy if:
    - You don't pay your premium when it is due;
    - You file a fraudulent claim;
    - TDI decides that keeping the policy violates the law;
    - Your driver's license or vehicle registration is suspended or revoked (unless you agree to exclude coverage for yourself as a driver under the policy); or
    - Any driver who lives with you, or who usually drives a vehicle covered by the policy, has their driver's license or vehicle registration suspended or revoked (unless you agree to exclude coverage for that person as a driver under the policy).

16. **Notice of cancellation.** If your insurance company cancels your policy, they must let you know by mail at least **10 days** before the effective date of the cancellation. Check your policy because your company may give you more than 10 days' notice.

17. **Your right to cancel.** You can cancel your policy at any time and get a refund of the unused premium.

18. **Refund of premium.** If you or your insurance company cancel your policy, the company must refund any unused premium within 15 business days from:
    - the date the company receives notice of the cancellation or
    - the date of cancellation, whichever is later.

    You must let your company know you want the refund sent to you. If not, they may refund the remaining premium by giving you a premium credit on the same policy.

19. **Limits on using claims history to change premium**. Your insurance company can't change your premium solely because of a claim you file that is not paid or payable under your policy.

20. **Timing of nonrenewal.** Your insurance company must renew your policy until it has been in effect for 1 year. If your policy is renewed, your company must continue to renew your policy until the yearly anniversary of the original effective date.

    For example, if your six-month policy was originally effective on January 1, 2050, your company must renew your policy until January 1, 2051. After that, your company may only refuse to renew your policy on the original effective date (in this example, January 1) of any future year.

    Note: There is an exception. See #22, "Nonrenewal for failure to cooperate."

21. **Notice of nonrenewal.** Your insurance company must send you a notice that they are not renewing your policy. They must let you know at least **30 days** before your policy expires, or you can require them to

renew your policy.

22. **Nonrenewal for failure to cooperate.** Your insurance company is required to nonrenew your policy if you or someone covered by your policy fails to cooperate in the investigation, settlement, or defense of a claim or action or the company is unable to contact the insured using reasonable efforts. The company must first give you a written notice that states:
(1) how you or someone covered by your policy failed or refused to cooperate, including failure as a result of the company's inability to contact you or them;
(2) the claim or action for which the company is requesting cooperation; and
(3) continued failure or refusal to cooperate will result in the company not renewing your policy.

23. **Not-at-fault claims.** Your insurance company cannot refuse to renew your policy solely because of any one of the following:
    - Claims involving damage from a weather-related incident that do not involve a collision, like damage from hail, wind, or flood.
    - Accidents or claims involving damage by contact with animals.
    - Accidents or claims involving damage caused by flying gravel, missiles, or other flying objects. However, if you have 3 of these claims in a three-year period, the company may increase your deductible on your next annual renewal date.
    - Towing and labor claims. However, once you have made 4 of these claims in a three-year period, the company may remove this coverage from your policy on your next annual renewal date.
    - Any other accident or claim that cannot reasonably be considered your fault, unless you have 2 of these claims or accidents in a one-year period.

24. **Limit on using credit information to nonrenew your policy.** An insurance company cannot refuse to renew your policy solely because of your credit.

25. **Limit on using age to nonrenew your policy.** An insurance company cannot refuse to renew your policy based solely on the age of any person covered by the policy. Your company also cannot require you to exclude a family member from coverage solely because they reached driving age.

26. **Protections from discrimination.** An insurance company cannot refuse to insure you; limit the coverage you buy; refuse to renew your policy; or charge you a different rate based on your race, color, creed, country of origin, or religion.

27. **Right to ask questions.** You can ask your insurance company a question about your policy. They cannot use your questions to deny, nonrenew, or cancel your coverage. Your questions also cannot be used to determine your premium.

    For example, you may ask:
    - General questions about your policy;
    - Questions about the company's claims filing process; and
    - Questions about whether the policy will cover a loss, unless the question is about damage: (a) that occurred and (b) that results in an investigation or claim.

28. **Notice of a "material change" to your policy.** If your insurance company does not want to cancel or nonrenew your policy, but wants to make certain material changes, then they must explain the changes in writing at least **30 days** before the annual renewal date**.** Material changes include:

- Giving you less coverage;
- Changing a condition of coverage; or
- Changing what you are required to do.

Instead of a notice of "material change" a company may choose to not renew your existing policy. If so, the company has to send a nonrenewal letter, but may still offer you a different policy.

Note: A company cannot reduce coverage during the policy period unless you ask for the change. If you ask for the change, the company does not have to send you a notice.

29. **Written explanation of cancellation or nonrenewal.** You can ask your insurance company to tell you in writing the reasons for their decision to cancel or not renew your policy. The company must explain in detail why they cancelled or nonrenewed your policy.

Figure 2: 28 TAC §5.9970(b)

DECLARACIÓN DE DERECHOS DEL CONSUMIDOR

Seguro de Automóvil Personal

¿Qué es la Declaración de Derechos?

Es un resumen básico de los derechos importantes que tiene bajo la ley de Texas. Las compañías de seguros tienen que darle una copia de esta Declaración de Derechos junto con su póliza. Es importante leer y entender su póliza.

La Declaración de Derechos ***no es***:

- Una lista completa de todos sus derechos,
- Parte de su póliza, o
- Una lista de todas sus obligaciones.

¿Tiene preguntas sobre estos derechos?

- Si tiene una duda sobre algún aspecto de su póliza, consulte a su agente o a la compañía de seguros.
- Si tiene preguntas o alguna queja, comuníquese con el Departamento de Seguros de Texas (Texas Department of Insurance (TDI), por su nombre y siglas en inglés):

  Para preguntas pro telefono, llame al: 1-800-252-3439

  Para preguntas por correo electrónico: ConsumerProtection@tdi.texas.gov

  Para presentar una queja a través del sitio web:

  https://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint-spanish.html

  Para presentar una queja por correo: Consumer Protection CO-CP
  P.O. Box 12030
  Austin, TX 78711-2030

- Para obtener más información sobre seguros, visite **https://www.opic.texas.gov/es/pagina-principal** o llame a la Oficina del Asesor Público de Seguros (Office of Public Insurance Counsel (OPIC), por su nombre y siglas en inglés) al 1-877-611-6742.

AVISO: Si recibe algún documento en inglés, llame a su agente o compañía de seguros y pregunte si lo tienen disponible en español.

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Dónde obtener información:

1. **La compañía de seguros.** Cuando reciba una copia de su póliza, también recibirá un "Aviso Importante" de la compañía. El aviso explica cómo ponerse en contacto con la compañía y cómo presentar una queja. Puede solicitar una copia completa de su póliza a la compañía en cualquier momento.

2. **La página de declaraciones.** La página de declaraciones, también llamada "página de dec," muestra: (a) el nombre y la dirección de la compañía de seguros, (b) las fechas efectivas de su póliza, (c) los vehículos y conductores asegurados, (d) cualquier conductor que esté excluido, (e) las cantidades y tipos de cobertura, y (f) sus deducibles.

3. **El Departamento de Seguros de Texas (TDI).** Tiene derecho a llamar gratis a TDI al 1-800-252-3439 para obtener información y ayuda sobre una queja contra una aseguradora. También puede encontrar información en el sitio web de TDI en www.tdi.texas.gov.

4. **Recursos para ayudarlo a comprar seguro.** La Oficina del Asesor Público de Seguros (OPIC) y TDI establecieron el sitio web www.HelpInsure.com para ayudarlo a comparar tarifas y coberturas de diferentes compañías de seguros. OPIC también tiene una herramienta en línea para ayudarlo a comparar las pólizas. Puede encontrar esta herramienta de comparación de pólizas en www.opic.texas.gov.

Lo que debería saber al presentar una reclamación

5. **Selección del taller de reparación y las piezas de repuesto.** Tiene derecho a elegir el taller de reparación y las piezas para su vehículo. La compañía de seguros no puede especificar la marca, el estilo, el tipo, la edad, el surtidor, el proveedor o la condición de las piezas o productos utilizados para reparar su auto, pero la aseguradora no está obligada a pagar más del costo razonable.

6. **Avisos requeridos sobre la reparación de autos.** La compañía de seguros tiene que entregarle un documento acerca de sus derechos respecto a la reparación de autos, como se indica a continuación:

    - **Reclamaciones presentadas por teléfono:** Aviso por escrito dentro de los 3 días hábiles o aviso verbal durante la llamada, seguido de un aviso por escrito dentro de los 15 días hábiles;
    - **Reclamaciones presentadas en persona:** Aviso por escrito en el momento en que presente su vehículo a la compañía aseguradora, al ajustador de seguros o a cualquier otra persona acerca de una reclamación sobre reparaciones; o
    - **Reclamaciones presentadas por escrito (incluyendo correo electrónico y fax):** Aviso por escrito dentro de los 3 días hábiles a partir de la fecha en que la compañía de seguros recibe la notificación de la reclamación.

7. **Plazos para tramitar reclamaciones y pagos.** Cuando presente una reclamación bajo su propia póliza, la compañía de seguros tendrá que cumplir con los siguientes plazos:

    - **Dentro de los 15 días después de la presentación de una reclamación:** La compañía tendrá que informarle que recibió su reclamación. La compañía también tendrá que comenzar su investigación y pedirle cualquier otra información que necesita.
    - **Dentro de los 15 días hábiles después de recibir toda la información necesaria:** La compañía tendrá que aprobar o rechazar su reclamación por escrito. Pueden extender este plazo hasta 45 días a partir de la fecha en que: (a) le informan que necesitan más tiempo y (b) le indican la razón.
    - **Dentro de 5 días hábiles después de que le informen que su reclamación ha sido aprobada:** La compañía tendrá que pagar la reclamación.

Nota: TDI puede extender estos plazos por 15 días más si ocurre una catástrofe relacionada con el clima.

Si la compañía no cumple con estos plazos, podría recibir la cantidad especificado en la reclamación, así como los intereses y los honorarios de los abogados.

8. **Explicación por escrito de la denegación de la reclamación.** La compañía de seguros tendrá que informarle por escrito por qué se rechazó su reclamación o alguna parte de su reclamación.

9. **Información no requerida para procesar su reclamación.** La compañía de seguros puede solicitar únicamente información que sea razonablemente necesaria para hacer la investigación de su reclamación. Sin embargo, no pueden solicitar sus declaraciones de impuestos federales, a menos que: (a) obtengan una orden judicial o (b) su reclamación implique una pérdida por incendio, pérdida de ganancias o pérdida de ingresos.

10. **Investigación razonable.** La compañía de seguros no puede negarse a pagar su reclamación sin hacer una investigación razonable de la reclamación. Debe mantener registros de todas las comunicaciones de reclamos (incluidas las notas de llamadas telefónicas) y otra documentación de reclamos (incluidos los estimados de daños y recibos).

11. **Recuperación del deducible.** Si otra persona pudiera tener responsabilidad legal por el daño a su auto y usted (a) presentó una reclamación y (b) pagó o está obligado a pagar un deducible bajo su propia póliza, entonces su compañía de seguros tendrá que:

    - Tomar medidas para recuperar su deducible a más tardar 1 año después de que se paga su reclamación; o
    - Reembolsar su deducible; o
    - Informarle que no se tomarán más medidas y que le permitirán que usted trate de cobrar su dinero (a) dentro de 1 año a partir de la fecha en que se paga su reclamación, o (b) al menos 90 días antes de que se venza el plazo para tomar acción legal (lo que suceda primero).

12. **Aviso de que se llegó a un acuerdo sobre la reclamación de responsabilidad.** Responsabilidad significa que usted es responsable de las lesiones o daños a la propiedad de otras personas. La compañía de seguros tiene que informarle por escrito:

    - Acerca de la primera oferta para resolver una reclamación contra usted dentro de los **10 días** después de la fecha en que se hizo la oferta.
    - Acerca de cualquier reclamación decidida en su contra dentro de los **30 días** después de la fecha del acuerdo.

Con quién hablar si hay desacuerdos sobre las reclamaciones

13. **Desacuerdos sobre reclamaciones.** Puede disputar la cantidad que le pagan en su reclamación o lo que está cubierto en su póliza. Usted puede:

    - Comunicarse con la compañía de seguros.
    - Comunicarse con el técnico de reparaciones o con el taller.
    - Comunicarse con un abogado para que le aconseje sobre sus derechos bajo la ley. El Colegio de Abogados del Estado de Texas (The State Bar of Texas, por su nombre en inglés) puede ayudarlo a buscar un abogado.
    - Contratar a un tasador calificado para que examine los daños a su propiedad.

- Presentar una queja al Departamento de Seguros de Texas (TDI).

Lo que debería saber sobre la renovación, la cancelación y la no renovación

La **renovación** significa que la compañía de seguros extiende su póliza por un período adicional.

La **cancelación** significa que, **antes de llegar al final del período de la póliza**, la compañía de seguros:

- Termina la póliza;
- Le ofrece menos cobertura o limita su cobertura; o
- Se niega a darle cobertura adicional a la cual tiene derecho bajo su póliza.

"Negar la renovación" y **"no renovación"** son términos que significan que su cobertura termina **al final del período de la póliza**. El período de la póliza aparece en la página de declaraciones de su póliza.

14. **Oferta de cobertura de protección contra conductores sin seguro/con insuficiente seguro y de protección para reclamaciones de lesiones personales.** En una nueva póliza, las compañías de seguros tienen que ofrecerle cobertura de Proctección contra Conductores sin Seguro o con Insuficiente Seguro (Uninsured Motorists Coverage (UM/UIM), por su nombre y siglas en inglés) y Protección para Lesiones Personales (Personal Injury Protection (PIP), por su nombre y siglas en inglés). Si rechaza esta cobertura, lo tiene que hacer por escrito. La compañía no está obligada a volver a ofrecerle estas coberturas al momento de la renovación, pero usted puede solicitarlas en cualquier momento.

15. **Cancelación por parte de la compañía de seguros de su póliza de auto personal.** Si su póliza ha estado vigente por **60 días o más**, la compañía solo puede cancelar su póliza si:
    - No paga su prima en la fecha indicada;
    - Presenta una reclamación fraudulenta;
    - TDI decide que mantener la póliza viola la ley.
    - Se le suspende o revoca su licencia de conducir o el registro de su vehículo (a menos que acepte excluirse a sí mismo de la cobertura como conductor bajo la póliza); o
    - Se le suspende o revoca la licencia de conducir o el registro de vehículo a cualquier conductor que viva con usted, o que generalmente maneje un vehículo cubierto bajo la póliza (a menos que acepte excluir a esa persona de la cobertura como conductor bajo la póliza).

16. **Aviso de cancelación.** Si la compañía de seguros cancela su póliza, tendrá que informarle por correo al menos **10 días** antes de la fecha en que se haga efectiva la cancelación. Revise su póliza porque es posible que su compañía de seguros le ofrezca más de 10 días de notificación.

17. **Su derecho a cancelar.** Puede cancelar su póliza en cualquier momento y obtener un reembolso de la prima no utilizada.

18. **Reembolso de la prima.** Si usted o la compañía de seguros cancela su póliza, la compañía tendrá que reembolsarle cualquier prima no utilizada dentro de los 15 días hábiles a partir de:
    - la fecha en que la compañía recibe la notificación de la cancelación, o
    - la fecha de cancelación, la que sea posterior.

    Tiene que informarle a la compañía que desea que se le envíe el reembolso. De lo contrario, podrían reembolsarle la prima restante ofreciéndole un crédito de prima en la misma póliza.

19. **Limitación al uso de su historial de reclamaciones para hacer cambios a la prima.** La compañía de seguros no puede cambiar su prima solo porque presentó una reclamación que no le pagó o que no se le pudo pagar bajo su póliza.

20. **Fechas relacionadas a la no renovación.** La compañía de seguros está obligada a renovar su póliza hasta que esté en vigencia por un año. Si le renuevan su póliza, la compañía de seguros tiene que seguir renovándola hasta llegar al aniversario de la fecha original en que se hizo efectiva.

    Por ejemplo, si su póliza de seis meses se hizo efectiva originalmente el 1 de enero del 2050, la compañía tiene que renovar su póliza hasta el 1 de enero del 2051. A partir de esa fecha, la compañía solo puede negarse a renovar su póliza en la fecha original en que se hizo efectiva (en este ejemplo, el 1 de enero) de cualquier año futuro.

    Nota: Hay una excepción. Vea #22, "No renovación por falta de cooperación".

21. **Aviso de no renovación.** La compañía de seguros tiene que enviarle un aviso de que no van a renovar su póliza. Tendrá que informarle al menos **30 días** antes del vencimiento de su póliza, o usted puede exigir que renueven su póliza.

22. **No renovación por falta de cooperación.** La compañía de seguros está obligada a no renovar su póliza si usted o alguien cubierto por su póliza no coopera en la investigación, el acuerdo de reclamo, o la defensa de un reclamo o acción, o la compañía no puede comunicarse con el asegurado haciendo esfuerzos razonables. La compañía de seguros primero tendrá que enviarle un aviso por escrito que explica:
    (1) cómo usted o alguien cubierto por su póliza falló se negó a cooperar, incluyendo fallas como resultado de la incapacidad de la compañía en comunicarse con usted o ellos;
    (2) el reclamo o acción por los cuales la compañía solicita cooperación; y
    (3) si sigue sin cooperar o continúa negándose a cooperar, la compañía de seguros no renovará su póliza.

23. **Reclamaciones sin culpa.** La compañía de seguros no puede negarse a renovar su póliza solo por darse uno de los siguientes hechos:

    - Reclamaciones referentes a daños por accidentes relacionados al clima que no tienen que ver con un choque, tal como daños por granizo, viento o inundación.
    - Accidentes o reclamaciones que tengan que ver con daños por contacto con animales.
    - Accidentes o reclamaciones que tengan que ver con daños causados por grava voladora, proyectiles o algún otro objeto volador. Sin embargo, si tiene 3 reclamaciones de este tipo en un período de tres años, la compañía puede aumentar su deducible en su próxima fecha de renovación anual.
    - Reclamaciones para cubrir gastos de grúa y de mano de obra. Sin embargo, una vez que haya presentado 4 reclamaciones de este tipo en un período de tres años, la compañía puede eliminar esta cobertura de su póliza en su próxima fecha de renovación anual.
    - Cualquier otro accidente o reclamación que razonablemente no se pueda considerar que haya sido culpa suya, a menos que tenga 2 reclamaciones o accidentes de este tipo en un período de un año.

24. **Limitación al uso de información crediticia para no renovar su póliza.** La compañía de seguros no puede negarse a renovar su póliza únicamente debido a la condición de su crédito.

25. **Limitación al uso de la edad para no renovar su póliza.** La compañía de seguros no puede negarse a renovar su póliza basándose únicamente en la edad de cualquier persona cubierta bajo la póliza. Su compañía tampoco puede exigirle que excluya a un miembro de su familia de la cobertura únicamente porque llegó a la edad de conducir.

26. **Protecciones contra la discriminación.** La compañía de seguros no puede negarse a asegurarle; limitar la cobertura que compra; negar la renovación de su póliza; o cobrarle una tarifa diferente debido a su raza, color, creencia, país de origen o religión.

27. **Derecho a hacer preguntas.** Puede hacerle una pregunta a la compañía de seguros sobre su póliza. No pueden usar sus preguntas para denegar, no renovar o cancelar su cobertura. Sus preguntas tampoco se pueden utilizar para determinar su prima.

    Por ejemplo, puede hacer:

    - Preguntas generales sobre su póliza;
    - Preguntas sobre el proceso de presentación de reclamaciones de la compañía; y
    - Preguntas sobre si la póliza cubrirá una pérdida, a menos que la pregunta sea sobre un daño: (a) que ocurrió y (b) que resulta en una investigación o reclamación.

28. **Aviso de un "cambio material" a su póliza.** Si la compañía de seguros no quiere cancelar o no renovar su póliza, pero desea hacer ciertos cambios materiales o importantes, tendrá que explicar los cambios por escrito al menos **30 días** antes de la fecha anual de renovación. Los cambios materiales incluyen:

    - Ofrecerle menos cobertura;
    - Cambiar una condición de la cobertura; o
    - Cambiar lo que se requiere que usted haga.

    En lugar de un aviso de "cambio material", la compañía puede optar por no renovar su póliza existente. Si es así, la compañía tiene que enviar una carta de no renovación, pero todavía puede ofrecerle una póliza diferente.

    Nota: La compañía no puede reducir la cobertura durante el período de la póliza a menos que usted solicite el cambio. Si usted solicita el cambio, la compañía no tiene que enviarle un aviso.

29. **Explicación por escrito de la cancelación o la no renovación.** Puede pedirle a la compañía de seguros que le informen por escrito los motivos de su decisión de cancelar o de no renovar su póliza. La compañía tendrá que darle una explicación detallada de por qué cancelaron o no renovaron su póliza.

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.

Texas Alcoholic Beverage Commission

Annual Production Limit Order

ADJUSTMENT OF PRODUCTION	§	**BEFORE THE**
	§	
LIMITS PURSUANT TO ALCOHOLIC	§	**TEXAS ALCOHOLIC BEVERAGE**
	§	
BEVERAGE CODE SECTION 62.122	§	**COMMISSION**

ANNUAL PRODUCTION LIMIT ORDER

Alcoholic Beverage Code Section 62.122(f) requires the Texas Alcoholic Beverage Commission (Commission) to annually adjust the production limit prescribed by Subsection (c)(2) of that section in an amount that is equal to the percentage of the state's population growth for the previous year, as determined by the State Demographer.

According to the State Demographer, the population of the State of Texas grew by 1.35 percent from January 1, 2022, to December 31, 2022.

The annual production limit prescribed by Order of the Commission dated March 22, 2022, was 184,406 barrels. Applying the 1.35 percent 2022 population growth figure to the 184,406-barrel production limit set forth in the 2022 Commission Order equals 2,489 barrels.

IT IS THEREFORE ORDERED THAT THE ANNUAL PRODUCTION LIMIT FOR 2023 UNDER ALCOHOLIC BEVERAGE CODE SECTION 62.122(c)(2) IS 186,895 BARRELS.

ENTERED AND EFFECTIVE on this the 28th day of March, 2023.

TEXAS ALCOHOLIC BEVERAGE COMMISSION

KEVIN J. LILLY
PRESIDING OFFICER

TRD-202301233

Matthew Cherry
Senior Counsel
Texas Alcoholic Beverage Commission
Filed: March 30, 2023

♦ ♦ ♦

Texas Animal Health Commission

Executive Director Order Declaring Quarantine for Control Areas in the State of Pennsylvania Due to Highly Pathogenic Avian Influenza

On March 23, 2023, the Executive Director of the Animal Health Commission issued an order declaring quarantine for the State of Pennsylvania Due to Highly Pathogenic Avian Influenza. The March 23, 2023, quarantine order is repealed and replaced with the following order:

The Texas Animal Health Commission (the "Commission") is authorized to establish a quarantine against all or a portion of a state in which an animal disease exists to protect livestock, exotic livestock, domestic fowl, and exotic fowl in this state from the disease.

Pursuant to Texas Agriculture Code §161.054, the Commission by rule may regulate the movement of animals and may restrict the intrastate movement of animals even though the movement of the animals is unrestricted in interstate commerce. Under Texas Agriculture Code §161.061, the Commission may establish a quarantine against a state to protect livestock, exotic livestock, domestic fowl, and exotic fowl from diseases the Commission determines require control or eradication under the Commission's disease control authority under Texas Agriculture Code §161.041.

As specified in Title 4, Texas Administrative Code §45.3, the Commission is required to protect all livestock, exotic livestock, domestic fowl, and exotic fowl from avian influenza. Under Title 4, Texas Administrative Code §51.5, if the Executive Director of the Commission determines that avian influenza exists in another state and deems it necessary to protect livestock in this state, the Executive Director may establish a quarantine against all of the state. A quarantine established by the Executive Director will be acted on by the Commission at the next appropriate meeting.

Highly Pathogenic Avian Influenza (HPAI)is an influenza virus that may cause illness and death in domestic poultry, fowl, and birds. HPAI is extremely infectious, and can spread rapidly from flock to flock and is often fatal to chickens. In domestic poultry, HPAI can cause morbidity and mortality rates between 90-100 percent, leading to detrimental economic consequences.

HPAI can spread easily through airborne transmission or indirectly through contaminated material. Due to the highly contagious nature of HPAI, rapid response to outbreaks is required. Movement control of animals, animal products, and other potentially contaminated materials is critical to prevent transmission of HPAI.

Currently, Pennsylvania is facing controlled outbreaks of HPAI. The Pennsylvania Department of Agriculture and the United States Department of Agriculture are actively working to eliminate all outbreaks of HPAI in Pennsylvania. While the measures taken in that state have reduced the incidents of HPAI, the Executive Director of the Commission finds that the outbreaks of HPAI that remains in Control Areas within Pennsylvania creates a high probability that domestic poultry and birds in those Pennsylvania Control Areas will have, develop, or be exposed to HPAI.

The Executive Director further finds that the risk of disease exposure from the movement of animals, equipment, vehicles and other fomites from the Pennsylvania Control Areas to Texas could lead to disease exposure across Texas.

The Executive Director, therefore, has determined that the remaining outbreak of HPAI in the Control Areas in the State of Pennsylvania poses a threat to animal health in Texas.

To protect animal health in this state, the Executive Director imposes a quarantine for the Control Areas in the State of Pennsylvania due to HPAI.

The Executive Director hereby orders the following quarantine:

All live poultry, unprocessed poultry, hatching eggs, unprocessed eggs, egg flats, poultry coops, cages, crates, other birds, and used poultry equipment originating from the current Control Areas in Pennsylvania must not enter Texas without express written consent from the Executive Director.

In accordance with Title 4, Texas Administrative Code §51.5 this quarantine order will be acted on by the Commission at the next appropriate meeting.

This order is issued pursuant to Texas Agriculture Code §§161.041, 161.054, and 161.061 and Title 4, Texas Administrative Code §51.5 and is effective immediately.

This order repeals the March 23, 2023, quarantine order titled "Executive Director Order Declaring Quarantine for the State of Pennsylvania Due to Highly Pathogenic Avian Influenza."

This order shall remain in effect pending further epidemiological assessment by the Texas Animal Health Commission.

Signed March 31, 2023.

Andy Schwartz, D.V.M.

Executive Director

Texas Animal Health Commission

TRD-202301254
Jeanine Coggeshall
General Counsel
Texas Animal Health Commission
Filed: March 31, 2023

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005 and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 04/10/23 - 04/16/23 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 04/10/23 - 04/16/23 is 18% for Commercial over $250,000.

The monthly ceiling as prescribed by §303.005 and §303.009[3] for the period of 04/01/23 - 04/30/23 is 18% for Consumer/Agricultural/Commercial credit through $250,000.

The monthly ceiling as prescribed by §303.005 and §303.009 for the period of 04/01/23 - 04/30/23 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-202301281
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: April 5, 2023

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075, requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075, requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **May 15, 2023.** TWC, §7.075, also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be received by 5:00 p.m. on **May 15, 2023.** 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: Braskem America, Incorporated; DOCKET NUMBER: 2021-0874-AIR-E; IDENTIFIER: RN102888328; LOCATION: La Porte, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §§115.722(c)(1), 116.115(a) and (c), and 122.143(4), New Source Review Permit Number 5527B, Special Conditions Number 1, Federal Operating Permit (FOP) Number O1424, General Terms and Conditions (GTC) and Special Terms and Condition (STC) Numbers 1.A and 11, and Texas Health and Safety Code (THSC), §382.085(b), by failing to prevent unauthorized emissions and failing to limit the highly reactive volatile organic compounds emissions to 1,200 pounds or less per one-hour block period; 30 TAC §101.201(a)(1)(B) and §122.143(4), FOP Number O1424, GTC and STC Number 2.F, and THSC, §382.085(b), by failing to submit an initial notification for a reportable emissions event no later than 24 hours after the discovery of an emissions event; and 30 TAC §101.201(b)(1)(G) and (H) and §122.143(4), FOP Number O1424, GTC and STC Number 2.F, and THSC, §382.085(b), by failing to identify all required information on the final record for a reportable emissions event; PENALTY: $74,536; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $37,268; ENFORCEMENT COORDINATOR: Danielle Porras, (713) 767-3682; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(2) COMPANY: Broadwind Heavy Fabrications, Incorporated; DOCKET NUMBER: 2022-0734-AIR-E; IDENTIFIER: RN105615850; LOCATION: Abilene, Taylor County; TYPE OF FACILITY: wind turbine support tower manufacturing plant; RULES VIOLATED: 30 TAC §122.143(4) and §122.145(2)(B) and (C), Federal Operating Permit (FOP) Number O3979, General Terms and Conditions (GTC), and Texas Health and Safety Code (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; and 30 TAC §§122.143(4) and 122.146(2), FOP Number O3979, GTC and Special Terms and Conditions Number 9, and THSC, §382.085(b), by failing to submit a permit compliance certification within 30 days of any certification period; PENALTY: $14,500; ENFORCEMENT COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(3) COMPANY: City of Plano; DOCKET NUMBER: 2021-1491-WQ-E; IDENTIFIER: RN101391670; LOCATION: Plano, Collin County; TYPE OF FACILITY: public water supply; RULE VIOLATED: TWC, §26.121(a)(2), by failing to prevent an unauthorized discharge of other waste into or adjacent to any water in the state; PENALTY: $18,750; ENFORCEMENT COORDINATOR: Monica Larina, (512) 239-0184; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: Clarity Homes, Ltd.; DOCKET NUMBER: 2022-0060-WQ-E; IDENTIFIER: RN110464385; LOCATION: Aledo, Parker County; TYPE OF FACILITY: large construction site; RULES VIOLATED: 30 TAC §281.25(a)(4) and Texas Pollutant Discharge Elimination System (TPDES) General Permit Number TXR15418Q Part III, Section F(2)(a)(ii), by failing to properly select, install, and maintain control measures according to the manufacturer's or designer's specifications; 30 TAC §281.25(a)(4) and TPDES General Permit Number TXR15418Q Part III, Section (G)(4)(b), by failing to design, install, implement, and maintain effective pollution prevention measures to minimize the exposure of building materials, building products, construction wastes, trash, landscape materials, fertilizers, pesticides, herbicides, detergents, sanitary waste, and other materials present at the site to precipitation and to stormwater; and 30 TAC §281.25(a)(4) and TPDES General Permit Number TXR15418Q Part III, Section (G)(5)(a), by failing to minimize the discharge of concrete wastewater; PENALTY: $11,250; ENFORCEMENT COORDINATOR: Ellen Ojeda, (512) 239-2581; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(5) COMPANY: H. L. ZUMWALT CONSTRUCTION, INCORPORATED; DOCKET NUMBER: 2021-1120-MLM-E; IDENTIFIER: RN105835375; LOCATION: Mico, Medina County; TYPE OF FACILITY: mineral mining and processing and terminal and joint terminal maintenance for motor freight transportation; RULES VIOLATED: 30 TAC §213.4(j) and Edwards Aquifer Protection Plan (EAPP) ID Number 13-09110601, Standard Condition Number 6, by failing to obtain approval of a modification to an approved Water Pollution Abatement Plan (WPAP) prior to commencing a regulated activity over the Edwards Aquifer Recharge Zone; 30 TAC §213.4(k) and EAPP ID Number 13-09110601, Standard Conditions Number 2, by failing to comply with the provisions of the approved WPAP; 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) Multi-Sector General Permit (MSGP) Number TXR05Z243,

Part III, Section A.1(a)(5) and A.2, by failing to establish a team and identify team members who will be responsible for developing and revising the stormwater pollution prevention plan (SWP3); 30 TAC §305.125(1) and TPDES MSGP Number TXR05Z243, Part III, Section A.3(a), (b), and (d), by failing to identify and describe all activities and significant materials that may potentially be pollutant sources in the SWP3; 30 TAC §305.125(1) and TPDES MSGP Number TXR05Z243, Part III, Section A.4(a)(1), (c), (d)(1), and (f), by failing to implement all pollution prevention practices that are necessary to protect water quality in the receiving waters; and 30 TAC §305.125(1) and TPDES MSGP Number TXR05Z243, Part III, Sections B.1(c), B.2(c), B.3, and B.5(c), by failing to conduct inspections of disturbed areas as specified in the permit; PENALTY: $18,675; ENFORCEMENT COORDINATOR: Mark Gamble, (512) 239-2587; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(6) COMPANY: Harris County Municipal Utility District 284; DOCKET NUMBER: 2021-1167-MWD-E; IDENTIFIER: RN103214839; LOCATION: Katy, Harris County; TYPE OF FACILITY: wastewater treatment facility; RULES VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a)(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0012949001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; PENALTY: $3,375; ENFORCEMENT COORDINATOR: Laura Draper, (254) 761-3012; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(7) COMPANY: HOLT TEXAS, LTD.; DOCKET NUMBER: 2021-1260-EAQ-E; IDENTIFIER: RN109697664; LOCATION: Georgetown, Williamson County; TYPE OF FACILITY: heavy equipment sales facility; RULES VIOLATED: 30 TAC §213.4(j) and Edwards Aquifer Protection Plan (EAPP) Number 11000585, Standard Conditions Number 6, by failing to obtain approval of a modification to an approved Water Pollution Abatement Plan prior to commencing a regulated activity over the Edwards Aquifer Recharge Zone; and 30 TAC §213.5(b)(5)(A) and EAPP Number 11000585, Standard Conditions Number 19, by failing to maintain permanent best management practices after construction; PENALTY: $6,250; ENFORCEMENT COORDINATOR: Mark Gamble, (512) 239-2587; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 339-2929.

(8) COMPANY: Jeffrey Cruise dba LONGHORN SEPTIC SERVICE L C and Amanda Marie Cruise; DOCKET NUMBER: 2021-1253-SLG-E; IDENTIFIER: RN102761384; LOCATION: Livingston, Polk County; TYPE OF FACILITY: domestic septage land application site; RULE VIOLATED: 30 TAC §305.125(1) and Domestic Septage Registration Number 710901, Section V.D.11, by failing to prevent uncontrolled public access to the land application site; PENALTY: $1,562; ENFORCEMENT COORDINATOR: Mark Gamble, (512) 239-2587; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(9) COMPANY: Key Largo Utilities LLC; DOCKET NUMBER: 2022-1228-UTL-E; IDENTIFIER: RN101244481; LOCATION: Freeport, Brazoria County; TYPE OF FACILITY: retail public utility, exempt utility, or provider or conveyor of potable or raw water service that furnishes water service; RULE VIOLATED: TWC, §13.1394(b)(2), by failing to adopt and submit to the TCEQ for approval an emergency preparedness plan that demonstrates the facility's ability to provide emergency operations; PENALTY: $645; ENFORCEMENT COORDINATOR: Samantha Salas, (512) 239-1543; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(10) COMPANY: MHP Ranchero Estates, LLC; DOCKET NUMBER: 2022-1501-UTL-E; IDENTIFIER: RN101270874; LOCATION: Kerrville, Kerr County; TYPE OF FACILITY: retail public utility, exempt utility, or provider or conveyor of potable or raw water service that furnishes water service; RULE VIOLATED: TWC, §13.1394(b)(2), by failing to adopt and submit to the TCEQ for approval an emergency preparedness plan that demonstrates the facility's ability to provide emergency operations; PENALTY: $510; ENFORCEMENT COORDINATOR: Corinna Willis, (512) 239-2504; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(11) COMPANY: Nouryon Surface Chemistry LLC; DOCKET NUMBER: 2021-1629-AIR-E; IDENTIFIER: RN100219393; LOCATION: Houston, Fort Bend County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §116.115(c) and §122.143(4), New Source Review Permit Number 9600, Special Conditions Number 1, Federal Operating Permit Number O1328, General Terms and Conditions and Special Terms and Conditions Number 13, and Texas Health and Safety Code, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $6,900; ENFORCEMENT COORDINATOR: Mackenzie Mehlmann, (512) 239-2572; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(12) COMPANY: SI Group, Incorporated; DOCKET NUMBER: 2021-0747-AIR-E; IDENTIFIER: RN102800315; LOCATION: Baytown, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §116.115(c) and §122.143(4), New Source Review Permit Number 9348, Special Conditions Number 13.E., Federal Operating Permit (FOP) Number O3320, General Terms and Conditions (GTC) and Special Terms and Conditions (STC) Number 12, and Texas Health and Safety Code (THSC), §382.085(b), by failing to monitor the primary operating parameters for the process heater; and 30 TAC §122.143(4) and §122.146(2), FOP Number O3320, GTC and STC Number 20, and THSC, §382.085(b), by failing to submit a permit compliance certification within 30 days of any certification period; PENALTY: $11,050; ENFORCEMENT COORDINATOR: Danielle Porras, (713) 767-3682; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(13) COMPANY: Southern Ionics Incorporated; DOCKET NUMBER: 2021-1604-AIR-E; IDENTIFIER: RN100639988; LOCATION: Pasadena, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §106.6(b), Permit by Rule Registration Number 78944, and Texas Health and Safety Code, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $5,000; SUPPLEMENTAL ENVIRONMENTAL PROJECT OFFSET AMOUNT: $2,000; ENFORCEMENT COORDINATOR: Desmond Martin, (512) 239-2814; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(14) COMPANY: The Chemours Company FC, LLC; DOCKET NUMBER: 2022-0081-AIR-E; IDENTIFIER: RN101623254; LOCATION: Ingleside, San Patricio County; TYPE OF FACILITY: chemical manufacturing plant; RULES VIOLATED: 30 TAC §116.115(c) and §122.143(4), New Source Review Permit Number 9074, Special Conditions Number 1, Federal Operating Permit (FOP) Number O4182, General Terms and Conditions (GTC) and Special Terms and Conditions (STC) Number 14, and Texas Health and Safety Code (THSC), §382.085(b), by failing to prevent unauthorized emissions; and 30 TAC §101.201(a)(1)(B) and §122.143(4), FOP Number O4182, GTC and STC Number 2.F, and THSC, §382.085(b), by failing to submit an initial notification for a reportable emissions event no later than 24 hours after the discovery of an emissions event; PENALTY: $5,320; ENFORCEMENT COORDINATOR: Amanda Diaz, (713) 422-8912;

REGIONAL OFFICE: 500 North Shoreline Boulevard, Suite 500, Corpus Christi, Texas 78401-0318, (361) 881-6900.

(15) COMPANY: TLN Properties, LLC dba Huber Garden Management; DOCKET NUMBER: 2022-1049-PWS-E; IDENTIFIER: RN101175115; LOCATION: Odessa, Ector County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.106(f)(2) and Texas Health and Safety Code, §341.031(a), by failing to comply with the acute maximum contaminant level of ten milligrams per liter for nitrate; PENALTY: $5,500; ENFORCEMENT COORDINATOR: Nick Lohret-Froio, (512) 239-4495; REGIONAL OFFICE: 9900 West IH-20, Suite 100, Midland, Texas 79706, (432) 570-1359.

(16) COMPANY: XTO ENERGY INCORPORATED; DOCKET NUMBER: 2022-0213-AIR-E; IDENTIFIER: RN105441810; LOCATION: Denver City, Yoakum County; TYPE OF FACILITY: oil and gas processing plant; RULES VIOLATED: 30 TAC §101.201(a)(1)(B) and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit an initial notification for a reportable emissions event no later than 24 hours after the discovery of an emissions event; and 30 TAC §116.115(c) and §116.615(2), Standard Permit Registration Number 105808, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $3,938; ENFORCEMENT COORDINATOR: Yuliya Dunaway, (210) 403-4077; REGIONAL OFFICE: 5012 50th Street, Suite 100, Lubbock, Texas 79414-3426, (806) 796-7092.

TRD-202301273
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: April 4, 2023

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Enforcement Orders

An agreed order was adopted regarding Barnett Gathering, LLC, Docket No. 2017-1487-AIR-E on March 31, 2023 assessing $49,875 in administrative penalties with $9,975 deferred. Information concerning any aspect of this order may be obtained by contacting Yuliya Dunaway, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding North Texas Municipal Water District, Docket No. 2019-1212-MLM-E on March 31, 2023 assessing $136,350 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Katy Montgomery, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was adopted regarding NAMOR Holdings LLC, Docket No. 2020-0417-MSW-E on March 31, 2023 assessing $12,000 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Megan Grace, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was adopted regarding MAPLE WATER SUPPLY CORPORATION, Docket No. 2020-1470-PWS-E on March 31, 2023 assessing $4,224 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Taylor Pearson, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding City of Sweeny, Docket No. 2021-0827-MWD-E on March 31, 2023 assessing $15,975 in administrative penalties with $3,195 deferred. Information concerning any aspect of this order may be obtained by contacting Mark Gamble, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Oxy Vinyls, LP, Docket No. 2021-1101-AIR-E on March 31, 2023 assessing $7,950 in administrative penalties with $1,590 deferred. Information concerning any aspect of this order may be obtained by contacting Mackenzie Mehlmann, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was adopted regarding Chris Rodriguez dba Rodriguez Tires & Wheels, Docket No. 2021-1104-MSW-E on March 31, 2023 assessing $1,250 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Jennifer Peltier, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Undine Texas, LLC, Docket No. 2021-1258-PWS-E on March 31, 2023 assessing $2,850 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Miles Wehner, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Roy Dawkins dba Shady Meadows Mobile Home Park, Docket No. 2021-1353-PWS-E on March 31, 2023 assessing $8,080 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Jennifer Peltier, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding NL CONSTRUCTION, L.L.C., Docket No. 2021-1494-WQ-E on March 31, 2023 assessing $11,500 in administrative penalties with $2,300 deferred. Information concerning any aspect of this order may be obtained by contacting Katy Montgomery, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was adopted regarding Chad Horace Currie dba CLC Landscaping, LLC, Docket No. 2021-1535-LII-E on March 31, 2023 assessing $2,369 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Cynthia Sirois, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Maverick County, Docket No. 2022-0443-PWS-E on March 31, 2023 assessing $7,656 in administrative penalties with $1,531 deferred. Information concerning any aspect of this order may be obtained by contacting Samantha Duncan, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding GEO SPECIALTY CHEMICALS, INC., Docket No. 2022-0727-PWS-E on March 31, 2023 assessing $3,125 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Ashley Lemke, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding WESTBOUND WATER SUPPLY CORPORATION, Docket No. 2022-0775-PWS-E on March 31, 2023 assessing $4,125 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Ashley Lemke, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-202301288
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 5, 2023

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Notice of Application and Public Hearing for an Air Quality Standard Permit for a Concrete Batch Plant with Enhanced Controls Proposed Air Quality Registration Number 171718

APPLICATION. JL Ready Mix Concrete, LLC, P.O. Box 779, Ozona, Texas 76943-0779 has applied to the Texas Commission on Environmental Quality (TCEQ) for an Air Quality Standard Permit for a Concrete Batch Plant with Enhanced Controls Registration Number 171718 to authorize the operation of a concrete batch plant. The facility is proposed to be located at the following driving directions: from the intersection of Farm-to-Market Road 2288 and Arden Road (Ranch-to-Market Road 853), travel west on Arden Road (Ranch-to-Market Road 853) for 0.27 miles. Site entrance is on the right, San Angelo, Tom Green County, Texas 76901. This application is being processed in an expedited manner, as allowed by the commission's rules in 30 Texas Administrative Code, Chapter 101, Subchapter J. This link to an electronic map of the site or facility's general location is provided as a public courtesy and not part of the application or notice. For exact location, refer to application. https://gisweb.tceq.texas.gov/LocationMapper/?marker=-100.523912,31.449052&level=13. This application was submitted to the TCEQ on February 7, 2023. The primary function of this plant is to manufacture concrete by mixing materials including (but not limited to) sand, aggregate, cement and water. The executive director has determined the application was technically complete on March 7, 2023.

PUBLIC COMMENT / PUBLIC HEARING. Public written comments about this application may be submitted at any time during the public comment period. The public comment period begins on the first date notice is published and extends to the close of the public hearing. Public comments may be submitted either in writing to the Texas Commission on Environmental Quality, Office of the Chief Clerk, MC-105, P.O. Box 13087, Austin, Texas 78711-3087, or electronically at www14.tceq.texas.gov/epic/eComment/. Please be aware that any contact information you provide, including your name, phone number, email address and physical address will become part of the agency's public record.

A public hearing has been scheduled, that will consist of two parts, an informal discussion period and a formal comment period. During the informal discussion period, the public is encouraged to ask questions of the applicant and TCEQ staff concerning the application, but comments made during the informal period will not be considered by the executive director before reaching a decision on the permit, and no formal response will be made to the informal comments. During the formal comment period, members of the public may state their comments into the official record. **Written comments about this application may also be submitted at any time during the hearing.** The purpose of a public hearing is to provide the opportunity to submit written comments or an oral statement about the application. **The public hearing is not an evidentiary proceeding.**

The Public Hearing is to be held:

Wednesday, May 17, 2023, at 6:00 p.m.

La Quinta Inn by Wyndham and Conference Center San Angelo

2307 West Loop 306

San Angelo, Texas 76904

RESPONSE TO COMMENTS. A written response to all formal comments will be prepared by the executive director after the comment period closes. The response, along with the executive director's decision on the application, will be mailed to everyone who submitted public comments and the response to comments will be posted in the permit file for viewing.

The executive director shall approve or deny the application not later than 35 days after the date of the public hearing, considering all comments received within the comment period, and base this decision on whether the application meets the requirements of the standard permit.

CENTRAL/REGIONAL OFFICE. The application will be available for viewing and copying at the TCEQ Central Office and the TCEQ San Angelo Regional Office, located at 622 South Oakes Suite K, San Angelo, Texas 76903-7035, during the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, beginning the first day of publication of this notice.

INFORMATION. If you need more information about this permit application or the permitting process, please call the Public Education Program toll free at (800) 687-4040. Si desea información en español, puede llamar al (800) 687-4040.

Further information may also be obtained from JL Ready Mix Concrete, LLC, P.O. Box 779, Ozona, Texas 76943-0779, or by calling Mr. Josh Butler, Elm Creek Environmental at (469) 946-8195.

Notice Issuance Date: March 29, 2023

TRD-202301286
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 5, 2023

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Notice of Correction to Agreed Order Number 2

In the September 16, 2022, issue of the *Texas Register* (47 TexReg 5873), the Texas Commission on Environmental Quality (commission) published notice of Agreed Orders, specifically Item Number 2, for Chilton Water Supply and Sewer Service Corporation; Docket Number 2022-0721-MWD-E. The error is as submitted by the commission.

The reference to the penalty should be corrected to read: "$5,137."

For questions concerning the error, please contact Michael Parrish at (512) 239-2548.

TRD-202301274
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: April 4, 2023

♦ ♦ ♦

Notice of Correction to Agreed Order Number 15

In the September 9, 2022, issue of the *Texas Register* (47 TexReg 5511), the Texas Commission on Environmental Quality (commission) published notice of Agreed Orders, specifically Item Number 15, for Zachary W. Clements; Docket Number 2021-1445-OSI-E. The error is as submitted by the commission.

The reference to rules violated: "Texas Health and Safety Code, §366.055(c)" should be corrected to read: "Texas Health and Safety Code, §366.051(c)."

For questions concerning these errors, please contact Michael Parrish at (512) 239-2548.

TRD-202301275
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: April 4, 2023

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Notice of District Petition

Notice issued March 31, 2023

TCEQ Internal Control No. D-11182022-038; 757 Churchill Development, L.P, a Texas limited partnership, (Petitioner) filed a petition with the Texas Commission on Environmental Quality (TCEQ) for the annexation of land into Van Alstyne Municipal Utility District No. 3 of Collin County (District) under Texas Water Code Chapters 49 and 54, Texas Local Government Code Section (§) 42.042 and the procedural rules of the TCEQ. The petition states that: (1) the Petitioner holds title to all the property in the proposed annexation area to be included in the District; (2) the proposed property annexation will contain approximately 71.126 acres of land located within Collin County; and (3) all of the land to be included within the proposed property annexation is within the extraterritorial jurisdiction of the City of Van Alstyne, Texas (City). Based on representations made by the Petitioner there are no lienholders on the property. The property proposed for annexation is located adjacent to the southern boundary of the district. Access to the annexation tract will be by County Road 429 and County Road 376. In accordance with Local Government Code §42.042 and Texas Water Code §54.016, the Petitioner submitted an amended petition to the City, requesting the City's consent to the creation of the District. After more than 90 days passed without receiving consent, the Petitioner submitted a petition to the City to provide water and sewer services to the proposed District. The 120-day period for reaching a mutually agreeable contract as established by the Texas Water Code §54.016(c) expired and the information provided indicates that the Petitioner and the City have not executed a mutually agreeable contract for service. Pursuant to Texas Water Code §54.016(d), failure to execute such an agreement constitutes authorization for the Petitioner to initiate proceedings to include the land within the proposed District.

INFORMATION SECTION

To view the complete issued notice, view the notice on our web site at www.tceq.texas.gov/agency/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the web site, type in the issued date range shown at the top of this document to obtain search results.

The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our web site at www.tceq.texas.gov.

TRD-202301289
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 5, 2023

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Notice of Receipt of Application and Intent to Obtain a Municipal Solid Waster Permit Amendment

Notice issued on April 05, 2023

Proposed Limited Scope Amendment to Permit No. 2397

Application. The City of Post, 105 East Main Street, Post, Garza County, Texas 79356, has applied to the Texas Commission on Environmental Quality (TCEQ) for a permit amendment to operate MSW Permit No. 2397 before closing MSW Permit No. 2227. MSW Permit No. 2227 must cease accepting Type I or IV waste before 2397 begins to accept the same waste type. The City of Post is also requesting to access MSW Permit No. 2397 using the existing gated access at adjacent MSW Permit No. 2227. The City of Post Type IAE/IVAE Landfill is located at 1637 CR 225 Post in Garza County, Texas 79356. The TCEQ received this application on February 16, 2023. The permit application is available for viewing and copying at The City of Post City Hall, 105 East Main Street, Post, Garza County, Texas 79356. The following link to an electronic map of the site or facility's general location is provided as a public courtesy and is not part of the application or notice: https://arcg.is/0LmKmb. For exact location, refer to application.

Additional Notice. TCEQ's Executive Director has determined the application is administratively complete and will conduct a technical review of the application. After technical review of the application is complete, the Executive Director may prepare a draft permit and will issue a preliminary decision on the application. Notice of the Application and Preliminary Decision will be published and mailed to those who are on the county-wide mailing list and to those who are on the mailing list for this application. That notice will contain the deadline for submitting public comments.

Public Comment/Public Meeting. You may submit public comments or request a public meeting on this application. The purpose of a public meeting is to provide the opportunity to submit comments or to ask questions about the application. TCEQ will hold a public meeting if the Executive Director determines that there is a significant degree of public interest in the application or if requested by a local legislator. A public meeting is not a contested case hearing.

Opportunity for a Contested Case Hearing. After the deadline for submitting public comments, the Executive Director will consider all timely comments and prepare a response to all relevant and material, or significant public comments. Unless the application is directly referred for a contested case hearing, the response to comments, and

the Executive Director's decision on the application, will be mailed to everyone who submitted public comments and to those persons who are on the mailing list for this application. If comments are received, the mailing will also provide instructions for requesting reconsideration of the Executive Director's decision and for requesting a contested case hearing. A person who may be affected by the facility is entitled to request a contested case hearing from the commission. A contested case hearing is a legal proceeding similar to a civil trial in state district court.

To Request a Contested Case Hearing, You Must Include The Following Items in Your Request: your name, address, phone number; applicant's name and permit number; the location and distance of your property/activities relative to the facility; a specific description of how you would be adversely affected by the facility in a way not common to the general public; a list of all disputed issues of fact that you submit during the comment period; and the statement "[I/we] request a contested case hearing." If the request for contested case hearing is filed on behalf of a group or association, the request must designate the group's representative for receiving future correspondence; identify by name and physical address an individual member of the group who would be adversely affected by the facility or activity; provide the information discussed above regarding the affected member's location and distance from the facility or activity; explain how and why the member would be affected; and explain how the interests the group seeks to protect are relevant to the group's purpose.

Following the close of all applicable comment and request periods, the Executive Director will forward the application and any requests for reconsideration or for a contested case hearing to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. The Commission may only grant a request for a contested case hearing on issues the requestor submitted in their timely comments that were not subsequently withdrawn.

If a hearing is granted, the subject of a hearing will be limited to disputed issues of fact or mixed questions of fact and law that are relevant and material to the Commission's decision on the application submitted during the comment period.

Mailing List. If you submit public comments, a request for a contested case hearing or a reconsideration of the Executive Director's decision, you will be added to the mailing list for this application to receive future public notices mailed by the Office of the Chief Clerk. In addition, you may request to be placed on: (1) the permanent mailing list for a specific applicant name and permit number; and/or (2) the mailing list for a specific county. To be placed on the permanent and/or the county mailing list, clearly specify which list(s) and send your request to TCEQ Office of the Chief Clerk at the address below.

Information Available Online. For details about the status of the application, visit the Commissioners' Integrated Database (CID) at www.tceq.texas.gov/goto/cid, Once you have access to the CID using the above link, enter the permit number for this application, which is provided at the top of this notice.

Agency Contacts and Information. All public comments and requests must be submitted either electronically at www14.tceq.texas.gov/epic/eComment/ or in writing to the Texas Commission on Environmental Quality, Office of the Chief Clerk, MC-105, P.O. Box 13087, Austin, Texas 78711-3087. Please be aware that any contact information you provide, including your name, phone number, email address and physical address will become part of the agency's public record. For more information about this permit application or the permitting process, please call the TCEQ's Public Education Program, Toll Free, at (800) 687-4040 or visit their website at www.tceq.texas.gov/goto/pep. Si desea información en español, puede llamar al (800) 687-4040.

Further information may also be obtained from the City of Post at the address stated above or by calling Mr. J. Rhett Parker, City Manager at (806) 495-2811.

TRD-202301287
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 5, 2023

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Notice of Request for Public Comment and Notice of a Public Meeting on Proposed Amendments to the Non-Rule Air Quality Standard Permit for Concrete Batch Plants

The Texas Commission on Environmental Quality (TCEQ or commission) is providing an opportunity for public comment and will conduct a public meeting to receive testimony regarding proposed amendments to the Non-Rule Air Quality Standard Permit for Concrete Batch Plants for issuance under the Texas Clean Air Act, Texas Health and Safety Code, §382.05195, Standard Permit and 30 Texas Administrative Code Chapter 116, Subchapter F, Standard Permits.

The proposed amendments will include an updated Air Quality Analysis (AQA) and corresponding revisions to certain provisions of the standard permit. The AQA is a report containing information that demonstrates that emissions at a concrete batch plant authorized by this standard permit would not cause or contribute to a violation of the National Ambient Air Quality Standards, exceed a state property line standard, or adversely affect human health and the environment. The proposed amendments to the standard permit include revised operational requirements, additional setback limitations, production limitations, and updated best management practices.

Proposed amendments to an air quality standard permit are subject to a minimum 30-day comment period; however, the commission is providing an extended comment period for this action. During the comment period, any person may submit written comments. After the comment period, TCEQ may revise the draft standard permit if appropriate. The final standard permit will then be considered by the commission for adoption. Upon adoption of the revised standard permit by the commission, the final standard permit and a response to all comments received will be made available on TCEQ's website.

The commission will hold a hybrid virtual and in-person public meeting on this proposal in Austin on Thursday, May 18, 2023, at 10:00 a.m. in Building E, Room 201S, at the TCEQ's central office located at 12100 Park 35 Circle. The meeting is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Spanish language interpretation services will be provided. Open discussion will not be permitted during the meeting; however, commission staff members will be available to discuss the proposal 30 minutes prior to the meeting.

Individuals who plan to attend the meeting virtually and want to provide oral comments and/or want their attendance on record must register by Tuesday, May 16, 2023. To register for the meeting, please email Rules@tceq.texas.gov and provide the following information: your name, your affiliation, your email address, your phone number, and whether or not you plan to provide oral comments during the meeting. Instructions for participating in the meeting will be sent on Wednesday, May 17, 2023, to those who register for the meeting.

Members of the public who do not wish to provide oral comments but would like to view the meeting may do so at no cost at: https://teams.microsoft.com/l/meetup-join/19%3ameeting_ODkyNjQ4OTQtM2E2ZC00ZDQzL-WFhNGItMDJlZmYwZDQ3NTgz%40thread.v2/0?context=%7b%22Tid%22%3a%22871a83a4-a1ce-4b7a-8156-3bcd93a08fba%22%2c%22Oid%22%3a%22e74a40ea-69d4-469d-a8ef-06f2c9ac2a80%22%2c%22IsBroadcastMeeting%22%3atrue%7d

Persons with special communication or other accommodation needs who are planning to attend the meeting should contact Sandy Wong, Office of Legal Services at (512) 239-1802 or 1-800-RELAY-TX (TDD). Requests should be made as far in advance as possible.

The TCEQ will also hold an informational meeting in Houston during the public comment period to answer questions about the proposed amendments. Oral testimony will not be accepted at the informational meeting. Details of the informational meeting (such as date, time, and location) will be posted on the TCEQ website at the link provided at the end of this document.

Written comments may be submitted to Gwen Ricco, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to *fax4808@tceq.texas.gov.* Electronic comments may be submitted at: *https://tceq.commentinput.com/comment/search.* File size restrictions may apply to comments being submitted via the TCEQ Public Comment system. All comments should reference Non-Rule Project No. 2022-033-OTH-NR. The comment period closes on June 14, 2023. Copies of the proposed amendments to the standard permit can be obtained from the commission's website at *https://www.tceq.texas.gov/permitting/air/newsourcereview/2023-amendment-concrete-batch-standard-permit.* For further information, please contact Michael Wilhoit, Project Manager, Air Permits Division, (512) 239-1222.

TRD-202301283
Guy Henry
Acting Deputy Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: April 5, 2023

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General Land Office

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 *Federal Register* pp. 1439 - 1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 26. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of March 4, 2023 to March 31, 2023. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§30.25, 30.32, and 30.41, the public comment period extends 30 days from the date published on the Texas General Land Office web site. The notice was published on the web site on Friday, April 7, 2023. The public comment period for this project will close at 5:00 p.m. on Sunday, May 7, 2023.

FEDERAL AGENCY ACTIVITIES:

Applicant: Department of Energy

Location: The proposed survey area is located at ~28.9-29.1°N, ~94.9-95.2°W, within Texas state water; approximately 22 km northeast of Freeport, Texas, and approximately 3 km from shore.

Project Description: The U.S. Department of Energy National Energy Technology Laboratory prepared a Draft Environmental Assessment to analyze the potential environmental, cultural, and social impacts of partially funding the University of Texas at Austin to conduct high-resolution 3-dimensional (HR3D) marine seismic surveys in the Gulf of Mexico. The proposed seismic surveys would be conducted from a research vessel on the shallow shelf in Texas state waters. The surveys would use up to 2 Generator-Injector airguns, with a total discharge volume of about 210 cubic inches, in water depths less than 20 meters. These surveys would be used to validate novel dynamic acoustic positioning technology for improving the accuracy in time and space of HR3D marine seismic technology. In particular, the seismic data would be used for field validation of monitoring, verification, and account technology for future offshore sub-seabed carbon storage.

Potential impacts of the proposed seismic surveys on the environment would be primarily a result of the operation of the airgun(s). Impacts from the surveys would be associated with increased underwater anthropogenic sounds, which could result in avoidance behavior by marine mammals, sea turtles, seabirds, and fish, and other forms of disturbance. An integral part of the planned surveys is a monitoring and mitigation program designed to minimize potential impacts of the proposed activities on marine animals present during the proposed surveys, and to document, as much as possible, the nature and extent of any effects. Injurious impacts to marine mammals, sea turtles, and seabirds have not been proven to occur near airgun(s). However, a precautionary approach would be taken, and the planned monitoring and mitigation measures would reduce the possibility of any effects.

Type of Application: Draft Environmental Assessment for Marine Geophysical Surveys in the Northwestern Gulf of Mexico, Fall 2023. DOE/EA-2191D.

CMP Project No: 23-1207-F2

FEDERAL AGENCY ACTIONS:

Applicant: PCI Nitrogen, LLC

Location: The project site is located in the Houston Ship Channel, located at 2001 Jackson Road, in Pasadena, Harris County, Texas.

Latitude & Longitude (NAD 83): 29.74333, -95.19025

Project Description: The applicant proposes to extend the time to perform previously authorized work and add authorization to utilize additional existing dredged material placement areas (DMPA). The previously authorized work includes the dredging of an approximately 157,000 cubic yards of material from an approximate 7.4-acre area to a depth of 40 below mean low tide, construct a new marine berth, placement of breasting and mooring dolphins, anchor buoys, a platform with a ship unloader and a receiving hopper with an onshore conveyor. Dredged material was authorized to be placed into the East/West Jones, Clinton, or House Stimson DMPA's. The proposed additional DMPA's include Glendale, Federal, Green's Bayou, Glanville, Beltway 8, Lost Lake, Goat Island, Peggy Lake, Spillman Island and Alexander Island DMPA's. Effluent resulting from hydraulic dredging is defined as a discharge of fill material. Effluent discharged from any of the authorized and any of the proposed DMPA's as a result of this project will require an individual water quality certification. This project will not result in a permanent loss of waters of the United States therefore the applicant has not proposed compensatory mitigation.

Type of Application: U.S. Army Corps of Engineers permit application # SWG-1998-02503. This application will be reviewed pursuant to Section 10 of the Rivers and Harbors Act of 1899 and Section 404 of the Clean Water Act. Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality as part of its certification under §401 of the Clean Water Act.

CMP Project No: 23-1200-F1

Applicant: Seaway Marine LLC dba Seaway Freeport Dock LLC

Location: The project site is located in Freeport Harbor Ship Channel and the Gulf of Mexico, at 151517 Old Quintana Road, in Freeport, Brazoria County, Texas 77541.

Latitude & Longitude (NAD 83): 28.938821, -95.318136

Project Description: The applicant is requesting a modification to their existing Department of the Army Permit to conduct new work dredging of approximately 1 million cubic yards of material within Seaway's existing 33-acre basin to lower the depth to -59 feet mean lower low water. Post dredge-event, Seaway is proposing the installation of 5,200 cubic yards of revetment along 2,440 linear feet of existing sheet pile. Material dredged from the basin is proposed for disposal in the Freeport New Work Offshore Dredge Material Disposal Site. Seaway also proposes to perform intermittent silt blade dredging to maintain dredge prism. The applicant has not proposed to mitigate for the proposed impacts.

Type of Application: U.S. Army Corps of Engineers permit application # SWG-1999-02529. This application will be reviewed pursuant to Section 10 of the Rivers and Harbors Act of 1899, Section 404 of the Clean Water Act, and Section 103 of the Marine Protection, Research and Sanctuaries Act. Note: The consistency review for this project may be conducted by The Railroad Commission of Texas as part of its certification under §401 of the Clean Water Act.

CMP Project No: 23-1202-F1

Applicant: Energy Transfer Nederland Terminal, LLC

Location: The project site is located in and adjacent to the Neches River, approximately 7.5 miles southeast of Beaumont, within Jefferson County, Texas.

Latitude & Longitude (NAD 83): 30.002552, -93.999444

Project Description: The applicant proposes to modify Department of the Army Permit SWG-2007-01401 to permanently discharge fill into an additional 331.181 acres of palustrine emergent (PEM), scrub-shrub (PSS) and forested (PFO) wetlands and 10.74 acres / 5,804 linear feet of water bodies, including 1,611 feet of shoreline along the Neches River, for facility expansion and reconfiguration at and adjacent to the Energy Transfer Nederland Terminal. The modified project boundary is inclusive of areas previously authorized for discharge of fill and dredging, resulting in impacts to a total of 465.947 acres of wetlands and 16.71 acres (7,281 linear feet) of water bodies within the expanded project footprint. The modified impacts also include temporary impacts to 0.31 acre (97 linear feet) of streams. All wetlands and waterbodies that were previously authorized for temporary impact are now proposed to be permanently impacted within the expanded project footprint.

Modified project components include additional dredging to construct the new Dock 7 and Materials Offloading (MOF) Dock at the terminal facility. Approximately 304,000 cubic yards of material within an approximate 9.2-acre area of the Neches River will be dredged to a depth of -42 feet Mean Lower Low Water and 356,000 cubic yards of material will be excavated within an approximately 8.01-acre area of land adjacent to the river to accommodate the construction and operation of Dock 7 and the MOF Dock. Approximately 272.07 cubic yards of material will be discharged below the Mean High Water line of 1,300 linear feet of the Neches River, and 627.93 cubic yards of material will be discharged in 0.95 acre of adjacent wetlands, for the installation of shoreline revetment at Dock 7 and the MOF Dock. Fill used onsite will consist of material dredged from the Neches River for Dock 7/MOF Dock construction, material dredged from the Neches River for the previously approved Dock C modifications, material excavated from federal Placement Area 23, and clean fill brought in from offsite. General fill material will consist of 6,466,961 cubic yards, with additional fill material of 622,261 cubic yards of crushed limestone and 12,280 cubic yards for concrete culverts and revetment. This modification incorporates all previously authorized project components in the permit modification issued on 27 May 2022 (see Background), including the modifications to Dock C structures and dredging, as well as 10 years of maintenance dredging at all other previously authorized docks (A-B Barge Dock, Dock 1, Dock 2, Dock 3, Dock 4, Dock 5, Dock 6, Layberth A, and Layberth D) and placement of dredged material, to include associated effluent discharge, onsite within the new development areas. The applicant is requesting authorization for 10 years for all project components.

The applicant stated that the purpose of the project is to build new and modernize existing facilities and infrastructure at Energy Transfer's Nederland Terminal that will allow for the manufacture, storage, and transfer of petroleum products onto deep draft vessels bound for domestic and export markets.

As part of the previous authorization issued on 27 May 2021, the applicant was required to purchase 71.043 forested Temporary Storage and Detention of Storage Water (TSSW) Functional Credit Units (FCUs), 63.753 forested Maintain Plant and Animal Communities (MPAC) FCUs, 73.480 forested Removal and Sequestration of Elements and Compounds (RSEC) FCUs, 8.993 palustrine scrub-shrub/emergent TSSW FCUs, 6.539 palustrine scrub-shrub/emergent MPAC FCUs, 6.739 palustrine scrub-shrub/emergent RSEC FCUs, from the Graham Creek Mitigation Bank and/or Pineywoods Mitigation Bank.

The applicant proposes to mitigate for the expanded project footprint impacts by purchasing an additional 8.827 physical FCUs, 37.160 biological FCUs, and 52.369 chemical FCUs for PFO wetland impacts, 17.329 physical FCUs, 16.317 biological FCUs, and 16.629 chemical FCUs for PSS wetland impacts, and 168.491 physical FCUs, 112.348 biological FCUs, and 134.669 chemical FCUs for PEM impacts from the Pineywoods Mitigation Bank.

Type of Application: U.S. Army Corps of Engineers permit application # SWG-2007-01401. This application will be reviewed pursuant to Section 10 of the Rivers and Harbors Act of 1899 and Section 404 of the Clean Water Act. Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality as part of its certification under §401 of the Clean Water Act.

CMP Project No: 23-1210-F1

Further information on the applications listed above, including a copy of the consistency certifications or consistency determinations for inspection, may be obtained from the Texas General Land Office Public Information Officer at 1700 N. Congress Avenue, Austin, Texas 78701, or via email at pialegal@glo.texas.gov. Comments should be sent to the Texas General Land Office Coastal Management Program Coordinator at the above address or via email at federal.consistency@glo.texas.gov.

TRD-202301285
Mark Havens
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: April 5, 2023

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Texas Health and Human Services Commission

Notice of Public Hearing on Proposed Updates to Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on April 24, 2023, at 9:00 a.m., to receive public comments on proposed updates to Medicaid payment rates resulting from Medical Policy Reviews and Special Review.

This hearing will be conducted as an online event. To join the hearing from your computer, tablet, or smartphone, register for the hearing in advance using the following link:

Registration URL: https://attendee.gotowebinar.com/register/3589142833223606105

After registering, you will receive a confirmation email containing information about joining the webinar. Instructions for dialing-in by phone will be provided after you register.

Members of the public can access a live stream of the meeting at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings. A recording of the hearing will be archived and accessible on demand at the same website under the "Archived" tab. The hearing will be held in compliance with Texas Human Resources Code section 32.0282, which requires public notice of and hearings on proposed Medicaid reimbursements.

Proposal. The effective date of the proposed payment rates for the topics presented during the rate hearing will be as follows:

Effective May 12, 2023

- Medical Policy Review:

-- TOS 1- Telephonic Codes

-- TOS 1- S8301

-- Vaccine Consultation (G0315)

- Special Review:

-- TOS 5 - Clinical Diagnostic Laboratory

Methodology and Justification. The proposed payment rates were calculated in accordance with Title 1 of the Texas Administrative Code:

Section 355.8023, Reimbursement Methodology for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS);

Section 355.8085, Reimbursement Methodology for Physicians and Other Practitioners;

Section 355.8441, Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (also known as Texas Health Steps); and

Section 355.8610, Reimbursement (methodology) for Clinical Laboratory Services.

Rate Hearing Packet. A briefing packet describing the proposed payment rates will be made available at https://pfd.hhs.texas.gov/rate-packets on or after April 14, 2023. Interested parties may obtain a copy of the briefing packet on or after that date by contacting Provider Finance by telephone at (512) 730-7401; by fax at (512) 730-7475; or by e-mail at PFDAcuteCare@hhs.texas.gov.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the Texas Health and Human Services Commission, Attention: Provider Finance, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030; by fax to Provider Finance at (512) 730-7475; or by e-mail to PFDAcuteCare@hhs.texas.gov. In addition, written comments may be sent by overnight mail to Texas Health and Human Services Commission, Attention: Provider Finance, Mail Code H-400, North Austin Complex, 4601 Guadalupe St, Austin, Texas 78751.

Preferred Communication. For quickest response please use e-mail or phone, if possible, for communication with HHSC related to this rate hearing.

Persons with disabilities who wish to participate in the hearing and require auxiliary aids or services should contact Provider Finance at (512) 730-7401 at least 72 hours before the hearing so appropriate arrangements can be made.

TRD-202301271
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: April 3, 2023

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Public Hearing - Proposed Medicaid Payment Rates for Biennial Calendar Fee Reviews

Notice of Public Hearing on proposed payment rates for Nurse Aide Training and Competency Evaluation Program (NATCEP); STAR Kids Community First Choice Personal Attendant and Habilitation (CFC PAS/HAB) Consumer Directed Services Option (CDS); and STAR Kids/STAR Health Prescribed Pediatric Extended Care Centers (PPECC).

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on May 19, 2023, at 9:00 a.m. to receive public comments on proposed Medicaid payment rates for Biennial Calendar Fee Reviews.

The public hearing will be held in the HHSC, John H Winters Building, Public Hearing Room 125, First Floor, 701 W. 51st Street, Austin, Texas 78751.

This hearing will be conducted both in-person and as an online event. To join the hearing from your computer, tablet, or smartphone, register for the hearing in advance using the following link: https://attendee.gotowebinar.com/register/2214045213189178454.

Webinar ID: 844-109-835.

After registering, you will receive a confirmation email containing information about joining the webinar. Instructions for dialing-in by phone will be provided after you register.

HHSC will also broadcast the public hearing; the broadcast can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings. The broadcast will be archived and accessible on demand on the same website. The hearing will be held in compliance with Texas Human Resources Code, Section 32.0282, which requires public notice of hearings on proposed Medicaid reimbursements.

Proposal. The effective date of the proposed payment rates for the topics presented during the rate hearing will be as follows:

Effective June 1, 2023

- STAR Kids CFC PAS/HAB CDS Option

- STAR Kids/STAR Health PPECC

Effective September 1, 2023

- NATCEP

Methodology and Justification.

STAR Kids CFC PAS/Hab CDS Rate

The proposed payment rates were determined following Title 1 of the Texas Administrative Code (1 TAC) §355.114, related to the Consumer Directed Services Payment Option.

STAR Kids/STAR Health (PPECC)

The proposed payment rates were determined following 1 TAC §355.9080 related to Reimbursement Methodology for Prescribed Pediatric Extended Care Centers.

NATCEP Rates

The proposed payment rates were determined following 1 TAC §355.307, related to Reimbursement Setting Methodology.

Briefing Package. A briefing package describing the proposed payment rates will be available at https://pfd.hhs.texas.gov/rate-packets no later than April 28, 2023. Interested parties may obtain a copy of the briefing package before the hearing by contacting the HHSC Provider Finance Department by telephone at (737) 867-7817; by fax at (512) 730-7475; or by email at PFD-LTSS@hhs.texas.gov. The briefing package will also be available at the public hearing.

Written Comments. Written comments regarding the proposed payment rates may be submitted instead of, or in addition to, oral testimony until 5:00 p.m. on the day of the hearing. Written comments may be sent by U.S. mail to the Texas Health and Human Services Commission, Attention: Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030; by fax to Provider Finance at (512) 730-7475; or by email to PFD-LTSS@hhs.texas.gov. In addition, written comments may be sent by overnight mail or hand delivered to the Texas Health and Human Services Commission, Attention: Provider Finance, Mail Code H-400, North Austin Complex, 4601 W. Guadalupe St., Austin, Texas 78751.

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact the HHSC Provider Finance Department by calling (512) 730-7401 at least 72 hours before the hearing so appropriate arrangements can be made.

TRD-202301272
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: April 4, 2023

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Public Notice - Texas State Plan Amendment

The Texas Health and Human Services Commission (HHSC) announces its intent to submit an amendment, transmittal number 23-0010, to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act.

The proposed amendment waives the counseling signature requirements at the dispensing of drugs during the Public Health Emergency. The requested effective date for the proposed amendment is March 1, 2020.

The proposed amendment is estimated to have no fiscal impact.

To obtain copies of the proposed amendment, interested parties may contact Kenneth Anzaldua, State Plan Lead, by mail at the Health and Human Services Commission, P.O. Box 13247, Mail Code H-600, Austin, Texas 78711; by telephone at (512) 438-4326; by facsimile at (512) 730-7472; or by email at Medicaid_Chip_SPA_Inquiries@hhsc.state.tx.us. Copies of the proposal will also be made available for public review at the local offices of the Texas Health and Human Services Commission.

TRD-202301263
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: April 3, 2023

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Texas Department of Housing and Community Affairs

Texas Housing Trust Fund Fiscal Year 2023 Texas Bootstrap Loan Program Notice of Funding Availability

The Texas Department of Housing and Community Affairs (the Department) announces the availability of approximately $6,293,636 in funding for the 2023 Texas Bootstrap Loan (Bootstrap) Program funded through the Texas Housing Trust Fund (Texas HTF). The funds include $5,721,488 in Project Costs, and $572,148 in Administrative funds. The funds will be made available to Bootstrap Reservation System Participants, with a current Loan Origination and Reservation System Access Agreement (Reservation Agreement). Applications for a Reservation Agreement are accepted on an ongoing basis.

Funds will be made available beginning April 18, 2023, in accordance with the NOFA. From time to time, additional funding may be made available under the NOFA through transfer of prior year balances, deobligated funds, and Program Income. Amendments will be published on the TDHCA website.

Information is available on the Department's web site at http://www.tdhca.state.tx.us/nofa.htm. Questions regarding the 2023 Texas Bootstrap Loan Program NOFA may be addressed to the Single Family and Homeless Programs Division via email at Bootstrap@tdhca.state.tx.us.

TRD-202301249
Bobby Wilkinson
Executive Director
Texas Department of Housing and Community Affairs
Filed: March 31, 2023

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Texas Department of Insurance

Company Licensing

Application for Langhorne Reinsurance (Arizona) Ltd, a foreign life, accident and/or health company, to change its name to Entrada Life Insurance Company. The home office is in Scottsdale, Arizona.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of John Carter, 1601 Congress Ave., Suite 6.900, Austin, Texas 78711.

TRD-202301284
Justin Beam
Chief Clerk
Texas Department of Insurance
Filed: April 5, 2023

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Texas Lottery Commission

Scratch Ticket Game Number 2466 "NEON 9s"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2466 is "NEON 9s". The play style is "multiple games".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2466 shall be $2.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2466.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 01, 02, 03, 04, 05, 06, 07, 08, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 9 SYMBOL, COLLECT SYMBOL, $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, $50.00, $500, $1,000 and $30,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 2466 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
02	TWO
03	THR
04	FOR
05	FIV
06	SIX
07	SVN
08	EGT
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
30	TRTY

9 SYMBOL	NINE
COLLECT SYMBOL	NINES
$2.00	TWO$
$4.00	FOR$
$5.00	FIV$
$10.00	TEN$
$20.00	TWY$
$40.00	FRTY$
$50.00	FFTY$
$500	FVHN
$1,000	ONTH
$30,000	30TH

E. Serial Number - A unique thirteen (13) digit number appearing under the latex scratch-off covering on the front of the Scratch Ticket. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

F. Bar Code - A twenty-four (24) character interleaved two (2) of five (5) Bar Code which will include a four (4) digit game ID, the seven (7) digit Pack number, the three (3) digit Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A fourteen (14) digit number consisting of the four (4) digit game number (2466), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 125 within each Pack. The format will be: 2466-0000001-001.

H. Pack - A Pack of the "NEON 9s" Scratch Ticket Game contains 125 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). One Ticket will be folded over to expose a front and back of one Ticket on each Pack. All Packs will be tightly shrink-wrapped. There will be no breaks between the Tickets in a Pack.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - Texas Lottery "NEON 9s" Scratch Ticket Game No. 2466.

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 "NEON 9s" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose fourteen (14) Play Symbols. GAME 1: If a player matches either of the YOUR NUMBERS Play Symbols to the LUCKY NUMBER Play Symbol, the player wins the prize for that number. GAME 2: If the player reveals 3 matching prize amounts, the player wins that amount. BONUS: If the player reveals 2 or more "9" Play Symbols in GAME 1 and GAME 2, the player wins the corresponding prize in the BONUS PRIZE LEGEND. (Only highest prize paid.) 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 fourteen (14) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly fourteen (14) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the fourteen (14) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the fourteen (14) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

B. GENERAL: A Ticket can win as indicated by the prize structure.

C. GENERAL: A Ticket can win up to four (4) times.

D. GENERAL: On winning and Non-Winning Tickets, the top cash prize of $30,000 will appear at least once, with respect to other parameters, play action or prize structure.

E. GAME 1: GAME 1 can win up to two (2) times.

F. GAME 1: Non-winning Prize Symbols will not match a winning Prize Symbol on a Ticket.

G. GAME 1: No matching non-winning YOUR NUMBERS Play Symbols will appear on a Ticket.

H. GAME 1: All YOUR NUMBERS Play Symbols will never equal the corresponding Prize Symbol (i.e., $2 and 02, $4 and 04, $5 and 05, $10 and 10 and $20 and 20).

I. GAME 1: On all Tickets, a Prize Symbol will not appear more than one (1) time in GAME 1 unless required by the prize structure to create multiple wins.

J. GAME 1: On Non-Winning Tickets, the LUCKY NUMBER Play Symbol will never match a YOUR NUMBERS Play Symbol.

K. GAME 1: On winning and Non-Winning Tickets, there will never be more than one (1) "9" (NINE) Play Symbol in GAME 1.

L. GAME 1: Tickets winning in GAME 1 will contain a LUCKY NUMBER Play Symbol that matches a YOUR NUMBERS Play Symbol.

M. GAME 1: The "9" (NINE) Play Symbol will never appear as a LUCKY NUMBER Play Symbol.

N. GAME 1: When a "9" (NINE) Play Symbol appears as a YOUR NUMBERS Play Symbol, the corresponding Prize Symbol will always be the "COLLECT" (NINES) Prize Symbol.

O. GAME 1: The "COLLECT" (NINES) Prize Symbol will only ever appear with a "9" (NINE) Play Symbol.

P. GAME 2: GAME 2 can win up to one (1) time.

Q. GAME 2: Winning Tickets will contain three (3) matching Prize Symbols.

R. GAME 2: A Prize Symbol will not appear more than three (3) times in GAME 2.

S. GAME 2: There will never be more than one (1) set of three (3) matching Prize Symbols in GAME 2.

T. GAME 2: Non-Winning Tickets will never have more than two (2) matching Prize Symbols.

U. GAME 2: On winning Tickets, all non-winning Prize Symbols will be different from winning Prize Symbols.

V. BONUS: On Non-Winning Tickets, there will never be more than one (1) "9" (NINE) Play Symbol across GAMES 1 & 2.

W. BONUS: On Tickets winning with the BONUS PRIZE LEGEND, there will be at least one (1) "9" (NINE) Play Symbol in each GAME 1 & 2, except on Tickets winning four (4) times and with respect to other play action, parameters or prize structure.

X. BONUS: The "9" (NINE) Play Symbol will appear at least once per Ticket.

Y. BONUS: No Ticket will contain more than five (5) "9" (NINE) Play Symbols.

Z. BONUS: The "9" (NINE) Play Symbols can win as per the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "NEON 9s" Scratch Ticket Game prize of $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, $50.00, $60.00, $90.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket

to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $40.00, $50.00, $60.00, $90.00, $100 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "NEON 9s" Scratch Ticket Game prize of $1,000 or $30,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "NEON 9s" Scratch Ticket Game prize the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

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 "NEON 9s" 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 "NEON 9s" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Prizes. There will be approximately 5,040,000 Scratch Tickets in Scratch Ticket Game No. 2466. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2466 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$2.00	577,920	8.72
$4.00	349,440	14.42
$5.00	40,320	125.00
$10.00	94,080	53.57
$20.00	47,040	107.14
$40.00	6,300	800.00
$50.00	3,780	1,333.33
$60.00	2,058	2,448.98
$90.00	1,470	3,428.57
$100	1,470	3,428.57
$500	1,785	2,823.53
$1,000	40	126,000.00
$30,000	5	1,008,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.48. 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. 2466 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket closing procedures and the Scratch Ticket Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing a Scratch Ticket, the player agrees to comply with, and abide by, these Game Procedures for Scratch Ticket Game No. 2466, 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-202301277

Bob Biard
General Counsel
Texas Lottery Commission
Filed: April 4, 2023

♦ ♦ ♦

Scratch Ticket Game Number 2502 "BINGO TIMES 20"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2502 is "BINGO TIMES 20". The play style is "bingo".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2502 shall be $5.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2502.

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: CHERRY SYMBOL, DIAMOND SYMBOL, HORSESHOE SYMBOL, BOAT SYMBOL, ANCHOR SYMBOL, WATERMELON SYMBOL, BAG OF MONEY SYMBOL, GOLD BAR SYMBOL, HEART SYMBOL, STAR SYMBOL, B01, B02, B03, B04, B05, B06, B07, B08, B09, B10, B11, B12, B13, B14, B15, I16, I17, I18, I19, I20, I21, I22, I23, I24, I25, I26, I27, I28, I29, I30, N31, N32, N33, N34, N35, N36, N37, N38, N39, N40, N41, N42, N43, N44, N45, G46, G47, G48, G49, G50, G51, G52, G53, G54, G55, G56, G57, G58, G59, G60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, FREE SYMBOL and X20 SYMBOL.

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. 2502 - 1.2D

PLAY SYMBOL	CAPTION
CHERRY SYMBOL	CHERRY
DIAMOND SYMBOL	DIAMND
HORSESHOE SYMBOL	HRSHOE
BOAT SYMBOL	BOAT
ANCHOR SYMBOL	ANCHOR
WATERMELON SYMBOL	WTRMLN
BAG OF MONEY SYMBOL	BAG
GOLD BAR SYMBOL	BAR
HEART SYMBOL	HEART
STAR SYMBOL	STAR
B01	
B02	
B03	
B04	
B05	
B06	
B07	
B08	
B09	
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FREE SYMBOL	
X20 SYMBOL	

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 Ticket number and the ten (10) digit Validation Number. The Bar Code appears on the back of the Scratch Ticket.

G. Game-Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (2502), a seven (7) digit Pack number, and a three (3) digit Scratch Ticket number. Scratch Ticket numbers start with 001 and end with 075 within each Pack. The format will be: 2502-0000001-001.

H. Pack - A Pack of the "BINGO TIMES 20" Scratch Ticket Game contains 075 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The Packs will alternate. One will show the front of Ticket 001 and back of 075 while the other fold will show the back of Ticket 001 and front of 075.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - Texas Lottery "BINGO TIMES 20" Scratch Ticket Game No. 2502.

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 "BINGO TIMES 20" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose the Play Symbols as indicated per the game instructions from the total one hundred eighty-one (181) Play Symbols. BINGO TIMES 20 PLAY INSTRUCTIONS: The player completely scratches the "CALLER'S CARD" area and the "5 BONUS NUMBERS" area to reveal a total of twenty-nine (29) Bingo Numbers. The player scratches only those Bingo Numbers on the six (6) "BINGO CARDS" that match the "CALLER'S CARD" Bingo Numbers and the "5 BONUS NUMBERS" Bingo Numbers. The player also scratches the "X20" spaces and the "FREE" spaces on the six (6) "BINGO CARDS". If a player matches all Bingo Numbers in a complete vertical, horizontal or diagonal line (five (5) Bingo Numbers, four (4) Bingo Numbers + "FREE" space, four (4) Bingo Numbers + "X20" space, or three (3) Bingo Numbers + "X20" space + "FREE" space), the player wins the prize in the corresponding prize legend for that "BINGO CARD". If the player matches all Bingo Numbers in all four (4) corners, the player wins the prize in the corresponding prize legend for that "BINGO CARD". If the player matches all Bingo Numbers to complete an "X" (eight (8) Bingo Numbers + "FREE" space), the player wins the prize in the corresponding prize legend for that "BINGO CARD". X20 PLAY INSTRUCTIONS: If a completed LINE pattern in any of the six (6) "BINGO CARDS" contains a "X20" symbol, the player wins 20 TIMES the LINE prize in the corresponding prize legend for that "BINGO CARD". Note: Only the highest prize per "BINGO CARD" will be paid. BONUS GAME PLAY INSTRUCTIONS: If the player reveals 2 matching Play Symbols in the BONUS GAME, the player wins $20. 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 one hundred eighty-one (181) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption. Crossword and Bingo style games do not typically have Play Symbol captions;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly one hundred eighty-one (181) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the one hundred eighty-one (181) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the one hundred eighty-one (181) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of Play Symbols.

B. GENERAL: A Ticket can win as indicated by the prize structure.

C. GENERAL: A Ticket can win up to six (6) times.

D. BONUS GAME: Winning Tickets will contain two (2) matching Play Symbols in the "BONUS GAME" play area and will win as per the prize structure.

E. BINGO: The number range used for each letter (B, I, N, G, O) will be as follows: B (1-15), I (16-30), N (31-45), G (46-60) and O (61-75).

F. BINGO: On winning and Non-Winning Tickets, there will be no matching "CALLER'S CARD" or "BONUS NUMBERS" Play Symbols.

G. BINGO: Each of the "CALLER'S CARD" and "BONUS NUMBERS" Play Symbols will appear on at least one of the six (6) "BINGO CARDS".

H. BINGO: Each "BINGO CARD" will contain twenty-three (23) numbers, one (1) "FREE" Play Symbol fixed in the center of the CARD and one (1) "X20" Play Symbol.

I. BINGO: The "I20" CALLER'S CARD and 5 BONUS NUMBERS Play Symbols will never appear in the "CALLER'S CARD" or the "5 BONUS NUMBERS" play areas.

J. BINGO: The "20" BINGO CARDS Play Symbol will never appear on a "BINGO CARD".

K. BINGO: There will be no matching Play Symbols on each "BINGO CARD" play area.

L. BINGO: The "X20" Play Symbol will appear once per "BINGO CARD" but will never appear in a corner or inside the "X" pattern of a "BINGO CARD".

M. BINGO: The "X20" Play Symbol will win 20 TIMES the prize and will win as per the prize structure.

N. BINGO: Prize for "BINGO CARDS" 1-6 are as follows:

CARD 1: LINE=$5. 4 CORNERS=$20. X=$100.

CARD 2: LINE=$10. 4 CORNERS=$25. X=$200.

CARD 3: LINE=$15. 4 CORNERS=$50. X=$400.

CARD 4: LINE=$20. 4 CORNERS=$100. X=$500.

CARD 5: LINE=$25. 4 CORNERS=$300. X=$1,000.

CARD 6: LINE=$50. 4 CORNERS=$500. X=$100,000.

O. BINGO: Each "BINGO CARD" on a Ticket will be different. Two (2) cards match if they have the same number Play Symbols in the same spots.

P. BINGO: Non-winning "BINGO CARDS" will match a minimum of three (3) number Play Symbols.

Q. BINGO: There can only be one (1) winning pattern on each "BINGO CARD".

2.3 Procedure for Claiming Prizes.

A. To claim a "BINGO TIMES 20" Scratch Ticket Game prize of $5.00, $10.00, $15.00, $20.00, $25.00, $30.00, $50.00, $100, $200, $300, $400 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $25.00, $30.00, $50.00, $100, $200, $300, $400 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "BINGO TIMES 20" Scratch Ticket Game prize of $1,000 or $100,000, the claimant must sign the winning Scratch Ticket and may present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning Scratch Ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "BINGO TIMES 20" Scratch Ticket Game prize, the claimant may submit the signed winning Scratch Ticket and a thoroughly completed claim form via mail. If a prize value is $1,000,000 or more, the claimant must also provide proof of Social Security number or Tax Payer Identification (for U.S. Citizens or Resident Aliens). Mail all to: Texas Lottery Commission, P.O. Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for Scratch Tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct the amount of a delinquent tax or other money from the winnings of a prize winner who has been finally determined to be:

1. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

2. in default on a loan made under Chapter 52, Education Code;

3. in default on a loan guaranteed under Chapter 57, Education Code; or

4. delinquent in child support payments in the amount determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

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 "BINGO TIMES 20" 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 "BINGO TIMES 20" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Ticket Prizes. There will be approximately 17,280,000 Scratch Tickets in Scratch Ticket Game No. 2502. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2502 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$5	1,728,000	10.00
$10	806,400	21.43
$15	403,200	42.86
$20	345,600	50.00
$25	345,600	50.00
$30	115,200	150.00
$50	148,800	116.13
$100	52,992	326.09
$200	3,504	4,931.51
$300	2,016	8,571.43
$400	1,680	10,285.71
$500	1,392	12,413.79
$1,000	336	51,428.57
$100,000	8	2,160,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.
**The overall odds of winning a prize are 1 in 4.37. The individual odds of winning for a particular prize level may vary based on sales, distribution, and number of prized 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. 2502 without advance notice, at which point no further Scratch Tickets in that game may be sold. The determination of the closing date and reasons for closing will be made in accordance with the Scratch Ticket closing procedures and the Instant 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. 2502, 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-202301282
Bob Biard
General Counsel
Texas Lottery Commission
Filed: April 5, 2023

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Texas Parks and Wildlife Department

Notice of a Public Comment Hearing on an Application for a Sand and Gravel Permit

The City of Austin Parks and Recreations Department has applied to the Texas Parks and Wildlife Department (TPWD) for an Individual Permit pursuant to Texas Parks and Wildlife Code, Chapter 86, to remove or disturb up to 10,000 cubic yards of sedimentary material within Barton Springs Pool in Travis County. The purpose of the removal or disturbance is maintenance of Barton Springs Swimming Pool through removal of flood-deposited gravel and silt. The location is approximately four miles downstream of Loop 360 and one-half mile upstream from Barton Springs Road in Austin, Texas. This notice is being published and mailed pursuant to 31 TAC §69.105(d).

TPWD will hold a public comment hearing regarding the application at 11:00 a.m. on Friday, May 5, 2023, at TPWD headquarters, located at 4200 Smith School Road, Austin, Texas 78744. A remote participation option will be available upon request. Potential attendees should contact Tom Heger at (512) 389-4583 or at tom.heger@tpwd.texas.gov for information on how to participate in the hearing remotely. The hearing is not a contested case hearing under the Texas Administrative Procedure Act. Oral and written public comment will be accepted during the hearing.

Written comments may be submitted directly to TPWD and must be received no later than 30 days after the date of publication of this notice

in the *Texas Register*. A written request for a contested case hearing from an applicant or a person with a justiciable interest may also be submitted and must be received by TPWD prior to the close of the public comment period. Timely hearing requests shall be referred to the State Office of Administrative Hearings. Submit written comments, questions, requests to review the application, or requests for a contested case hearing to: Tom Heger, TPWD, by mail: 4200 Smith School Road, Austin, Texas 78744; or e-mail tom.heger@tpwd.texas.gov.

TRD-202301248
James Murphy
General Counsel
Texas Parks and Wildlife Department
Filed: March 30, 2023

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Public Utility Commission of Texas

Notice of Application for Service Area Boundary Change

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on February 13, 2023, to amend certificates of convenience and necessity for service area boundary changes in Live Oak and McMullen counties.

Docket Style and Number: Joint Application of Nueces Electric Cooperative, Inc. and San Patricio Electric Cooperative, Inc. to Amend Certificates of Convenience and Necessity for Service Area Boundary Changes in Live Oak and McMullen Counties. Docket No. 54628.

The Application: Nueces Electric Cooperative, Inc. (NEC) and San Patricio Electric Cooperative, Inc. (SPEC) seek minor boundary changes to electric certificate of convenience and necessity (CCN) numbers 30126 and 30137, respectively. The minor boundary changes are being requested to address service area encroachments that have occurred over the past several years within NEC's and SPEC's respective service areas, to correctly reflect NEC's and SPEC's respective service area borders, and to allow existing customers to remain with their current service provider. The proposed new service area boundaries are also being sought to facilitate NEC's service to a landowner located within the Double Eagle II subdivision, which is subject to the proposed boundary change. No NEC or SPEC customers will be required to take service from an electric service provider other than their current service provider. NEC customers served in these areas will still remain the customers of NEC, and SPEC customers will remain the customers of SPEC.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by electronic mail at puc.texas.gov, by phone at (512) 936-7120, or toll-free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission through Relay Texas by dialing 7-1-1. All comments should reference Docket Number 54628.

TRD-202301253
Andrea Gonzalez
Rules Coordinator
Public Utility Commission of Texas
Filed: March 31, 2023

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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 48 (2023) is cited as follows: 48 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 "48 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 48 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the *Texas Register* office, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using *Texas Register* indexes, the *Texas Administrative Code* section numbers, or TRD number.

Both the *Texas Register* and the *Texas Administrative Code* are available online at: http://www.sos.state.tx.us. The *Texas Register* is available in an .html version as well as a .pdf version through the internet. For website information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The *Texas Administrative Code (TAC*) is the compilation of all final state agency rules published in the *Texas Register*. Following its effective date, a rule is entered into the *Texas Administrative Code*. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the *TAC*.

The *TAC* volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete *TAC* is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The Titles of the *TAC*, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
26. Health and Human Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the *Texas Administrative Code*; *TAC* stands for the *Texas Administrative Code*; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to Update: To find out if a rule has changed since the publication of the current supplement to the *Texas Administrative Code*, please look at the *Index of Rules*.

The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the *Texas Register*.

If a rule has changed during the time period covered by the table, the rule's *TAC* number will be printed with the *Texas Register* page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
1 TAC §91.1…….....950 *(P)*

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