TEXAS REGISTER

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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 November 28, 2023

Designating Christopher R. "Chris" Carmona of Houston as presiding officer of the Texas Diabetes Council for a term to expire at the pleasure of the Governor. Mr. Carmona is replacing Feyi Obamehinti, Ed.D. of Keller as presiding officer.

Designating William R. "Bill" Rector, M.D. of Kerrville as president of the Upper Guadalupe River Authority for a term to expire at the pleasure of the Governor.

Pursuant to HB 1755, 88th Legislature, Regular Session, appointed to the Lone Star Workforce of the Future Fund Advisory Board for a term to expire September 1, 2025, Manuel "Manny" Salazar, III of Kingsville, Texas.

Greg Abbott, Governor

TRD-202304382

♦ ♦ ♦

Proclamation 41-4082

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, I, Greg Abbott, Governor of Texas, issued a disaster proclamation on May 31, 2021, certifying under Section 418.014 of the Texas Government Code that the surge of individuals unlawfully crossing the Texas-Mexico border posed an ongoing and imminent threat of disaster for a number of Texas counties and for all state agencies affected by this disaster; and

WHEREAS, I amended the aforementioned proclamation in a number of subsequent proclamations, including to modify the list of affected counties and therefore declare a state of disaster for those counties and for all state agencies affected by this disaster; and

WHEREAS, the certified conditions continue to exist and pose an ongoing and imminent threat of disaster as set forth in the prior proclamations;

NOW, THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby renew the aforementioned proclamation and declare a disaster for Bee, Brewster, Brooks, Caldwell, Cameron, Chambers, Colorado, Crane, Crockett, Culberson, DeWitt, Dimmit, Duval, Edwards, El Paso, Frio, Galveston, Goliad, Gonzales, Hidalgo, Hudspeth, Jackson, Jeff Davis, Jim Hogg, Jim Wells, Kenedy, Kerr, Kimble, Kinney, Kleberg, La Salle, Lavaca, Live Oak, Mason, Maverick, McCulloch, McMullen, Medina, Menard, Midland, Pecos, Presidio, Real, Refugio, San Patricio, Schleicher, Sutton, Terrell, Throckmorton, Uvalde, Val Verde, Victoria, Webb, Wharton, Wilbarger, Wilson, Zapata, and Zavala Counties and for all state agencies affected by this disaster. All orders, directions, suspensions, and authorizations provided in the Proclamation of May 31, 2021, as amended and renewed in subsequent proclamations, are in full force and effect.

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 20th day of November, 2023.

Greg Abbott, Governor

TRD-202304343

♦ ♦ ♦

Proclamation 41-4083

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, I, GREG ABBOTT, Governor of the State of Texas, issued a disaster proclamation on August 11, 2023, certifying that wildfires that began on July 24, 2023, posed an imminent threat of widespread or severe damage, injury, or loss of life or property in several counties; and

WHEREAS, the Texas Division of Emergency Management has confirmed that those same wildfire conditions continue to exist in these and other counties in Texas, with the exception of Archer, Atascosa, Bell, Bexar, Brazos, Burnet, Calhoun, Callahan, Clay, Coke, Coleman, Comal, Cooke, Coryell, Denton, Dickens, Eastland, Edwards, Fannin, Fayette, Gregg, Guadalupe, Hamilton, Hood, Karnes, Kendall, Kleberg, Lampasas, Lavaca, Live Oak, Mills, Orange, Palo Pinto, Parker, Pecos, Randall, Rockwall, Runnels, Sabine, San Saba, Shackelford, Somervell, Stephens, Sutton, Tyler, Wichita, Wilson, Yoakum, and Young Counties;

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 Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brooks, Cameron, Carson, Castro, Cochran, Collin, Crockett, Culberson, Dimmit, Donley, Duval, Ector, El Paso, Garza, Glasscock, Gray, Hale, Hall, Haskell, Hemphill, Hidalgo, Hudspeth, Jack, Jasper, Jeff Davis, Jim Hogg, Kenedy, King, Kinney, Knox, LaSalle, Lamb, Lipscomb, Martin, Maverick, Medina, Mitchell, Moore, Newton, Nolan, Oldham, Potter, Presidio, Reagan, Reeves, Refugio, Roberts, San Patricio, Scurry, Sherman, Starr, Stonewall, Terrell, Throckmorton, Upton, Val Verde, Ward, Webb, Wheeler, Wilbarger, Willacy, Winkler, Wise, 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 20th day of November, 2023.

Greg Abbott, Governor

TRD-202304344

♦ ♦ ♦

Proclamation 41-4084

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, with the exception of Anderson, Andrews, Archer, Bosque, Brazoria, Brewster, Burleson, Clay, Collin, Comanche, Concho, Cooke, Crockett, Dallas, Denton, Edwards, Ellis, Falls, Freestone, Frio, Gaines, Galveston, Glasscock, Grayson, Grimes, Harris, Harrison, Henderson, Hill, Hood, Houston, Howard, Irion, Jack, Johnson, Kaufman, Kimble, Kinney, Martin, McCulloch, McLennan, Menard, Milam, Montague, Montgomery, Nacogdoches, Navarro, Panola, Pecos, Polk, Reagan, Real, Robertson, Rockwall, Runnels, Rusk, San Jacinto, Schleicher, Smith, Somervell, Starr, Tarrant, Taylor,

Tom Green, Travis, Trinity, Upton, Van Zandt, Walker, Ward, Webb, Wise, and Zapata Counties;

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 Angelina, Aransas, Atascosa, Austin, Bandera, Bastrop, Bee, Bell, Bexar, Blanco, Brazos, Burnet, Caldwell, Calhoun, Callahan, Cameron, Chambers, Childress, Coke, Colorado, Comal, Coryell, Crane, Culberson, DeWitt, Eastland, Ector, El Paso, Erath, Fayette, Fort Bend, Gillespie, Goliad, Gonzales, Guadalupe, Hamilton, Hardeman, Hardin, Hays, Hidalgo, Hudspeth, Jackson, Jasper, Jeff Davis, Jefferson, Karnes, Kendall, Kerr, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Live Oak, Llano, Loving, Madison, Mason, Matagorda, Maverick, Medina, Midland, Mills, Newton, Orange, Palo Pinto, Parker, Presidio, Reeves, Refugio, Sabine, San Augustine, San Saba, Shelby, Sutton, Tyler, Uvalde, Victoria, Waller, Washington, Wharton, Wichita, Wilbarger, Williamson, Wilson, and Winkler 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 20th day of November, 2023.

Greg Abbott, Governor

TRD-202304345

♦ ♦ ♦

Proclamation 41-4085

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, the constitutional actions taken by the Texas House of Representatives on May 9, 2023, as reflected in the adoption of House Resolution No. 1542, have caused a vacancy to exist in Texas State House of Representatives District No. 2, which consists of Hopkins, Hunt, and Van Zandt Counties; and

WHEREAS, a special election to fill the vacancy in Texas State House of Representatives District No. 2 was held on Tuesday, November 7, 2023, and the results of that special election have been officially declared; and

WHEREAS, no candidate in the special election received a majority of the votes cast, as required by Section 203.003 of the Texas Election Code; and

WHEREAS, Section 2.021 of the Texas Election Code requires that a runoff election be held if no candidate receives the votes necessary to be elected; and

WHEREAS, Section 2.025(d) of the Texas Election Code provides that a runoff election for a special election to fill a vacancy in the legislature must be held not earlier than the 70th day or later than the 77th day after the date the final canvass of the main election is completed; and

WHEREAS, Section 3.003(a)(3) of the Texas Election Code requires a special runoff election to be ordered by proclamation of the governor;

NOW, THEREFORE, I, GREG ABBOTT, Governor of Texas, under the authority vested in me by the Constitution and Statutes of the State of Texas, do hereby order a special runoff election to be held in Texas State House of Representatives District No. 2 on Tuesday, January 30, 2024, for the purpose of electing a state representative to serve out the unexpired term of Mr. Bryan Slaton.

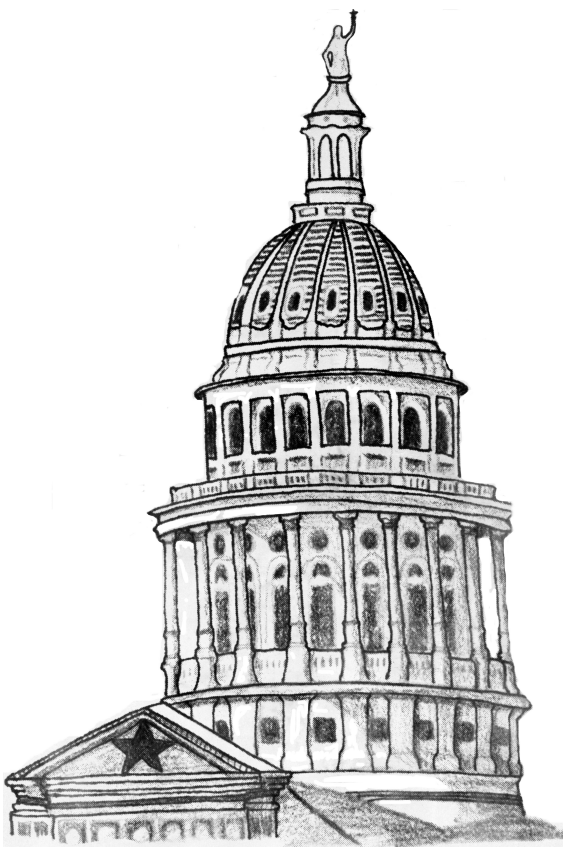
Early voting by personal appearance shall begin on Monday, January 22, 2024, in accordance with Sections 85.00l(b) and (c) of the Texas Election Code.

A copy of this order shall be mailed immediately to the county judges of all counties contained within Texas State House of Representatives District No. 2, and all appropriate writs shall be issued and all proper proceedings shall be followed to the end so that said runoff election may be held to fill the vacancy in Texas State House of Representatives District No. 2 and its result proclaimed in accordance with law.

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 20th day of November, 2023.

Greg Abbott, Governor

♦ ♦ ♦



THE ATTORNEY GENERAL

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

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

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

Requests for Opinions

RQ-0520-KP

Requestor:

The Honorable Dee Hobbs

Williamson County Attorney

405 M.L.K. Street, #7

Georgetown, Texas 78626

Re: Whether a member of the public may obtain copies of spoiled ballots on the 61st day following election day (RQ-0520-KP)

Briefs requested by December 18, 2023

RQ-0521-KP

Requestor:

The Honorable John Creuzot

Dallas County District Attorney

500 Elm Street, Suite 6300

Dallas, Texas 75202

Re: Construction of Health & Safety Code section 571.018 with respect to payment of court filing fees and costs in a civil mental health commitment case (RQ-0521-KP)

Briefs requested by December 18, 2023

RQ-0522-KP

Requestor:

The Honorable Paul Bettencourt

Chair, Senate Committee on Local Government

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Whether a jurisdiction offering its employees an incentive to vote in an election provides a benefit as consideration for the employee's decision to vote within the scope of Penal Code section 36.02 or 18 U.S.C section 597 (RQ-0522-KP)

Briefs requested by December 18, 2023

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

TRD-202304354
Austin Kinghorn
General Counsel
Office of the Attorney General
Filed: November 21, 2023

♦ ♦ ♦

Opinions

Opinion No. KP-0451

Mr. Mark Bronson, D.C.

President

Texas Board of Chiropractic Examiners

1801 North Congress, Suite 10.500

Austin, Texas 78701

Re: Whether the Texas Board of Chiropractic Examiners has discretion to suspend or revoke a chiropractor's license under Texas Occupations Code section 201.5065 if the chiropractor is convicted of certain offenses (RQ-0510-KP)

S U M M A R Y

Occupations Code chapter 201 provides for the regulation of chiropractors by the Board of Chiropractic Examiners. Occupations Code chapter 53 is generally applicable to all licensing authorities. Occupations Code section 201.5065 states the Board "shall" suspend or revoke a chiropractor's license under the circumstances listed. Occupations Code sections 53.021 and 201.502 state the Board "may" suspend a license, revoke a license, or take other disciplinary actions under the circumstances set forth in each statute. Section 201.5065 is the more specific provision when compared with either section 53.021 or section 201.502. While relevant portions of section 53.021 and section 201.502 were adopted after section 201.5065, there is no manifest intent for either provision to prevail over section 201.5065. Therefore, a court would likely conclude Occupations Code section 201.5065 prevails over section 53.021 and section 201.502 in the event of a conflict.

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

TRD-202304353

Austin Kinghorn
General Counsel
Office of the Attorney General
Filed: November 21, 2023

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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 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER B. DISEASE DETECTION AND RESPONSE

DIVISION 2. CHRONIC WASTING DISEASE - COMPREHENSIVE RULES

31 TAC §65.95

Pursuant to Parks and Wildlife Code, §12.027, and Government Code, §2001.034, the executive director of the Texas Parks and Wildlife Department (the department) adopts, on an emergency basis, an amendment to 31 TAC §65.95, concerning Movement of Breeder Deer, in response to the ongoing and most recent detections of chronic wasting disease (CWD) in additional deer breeding facilities.

The department's executive director has determined that the nature of CWD, it's continued spread, and its recent detection in additional deer breeding facilities in Brooks, Frio, Zavala, Kimble, and Cherokee counties pose an immediate danger to white-tailed deer, which is a species authorized to be regulated by the department, and that the adoption of rules on an emergency basis with fewer than 30 days' notice is necessary to address this immediate danger.

The department's response to the emergence of CWD in captive and free-ranging populations is guided by the department's CWD Management Plan (Plan) https://tpwd.texas.gov/huntwild/wild/diseases/cwd/plan.phtml. Developed in 2012 in consultation with the Texas Animal Health Commission, other governmental entities and conservation organizations, and various advisory groups consisting of landowners, hunters, deer managers, veterinarians, and epidemiologists, the Plan sets forth the department's CWD management strategies and informs regulatory responses to the detection of the disease in captive and free-ranging cervid populations in the state of Texas. The Plan is intended to be dynamic; in fact, it must be so in order to accommodate the growing understanding of the etiology, pathology, and epidemiology of the disease and the potential management pathways that emerge as it becomes better understood through time. The Plan proceeds from the premise that disease surveillance and active management of CWD once it is detected are absolutely critical to containing it on the landscape.

This emergency action replaces an emergency adoption (48 TexReg 4337) filed on July 24, 2023, which expires on the date of this filing; however, provisions affecting 31 TAC §65.911, concerning Prohibited Acts, have been removed. The department is therefore specifying a 60-day period of effectiveness for this emergency adoption so as not to exceed a total period of effectiveness of 180 days for the remaining provisions (§65.95). On November 2, 2023, the Texas Parks and Wildlife Commission adopted an amendment to §65.95. The department will withdraw this emergency action when the permanent amendment to §65.95 takes effect.

CWD is a fatal neurodegenerative disorder that affects some cervid species, including white-tailed deer, mule deer, elk, red deer, sika, and their hybrids (susceptible species). It is classified as a TSE (transmissible spongiform encephalopathy), a family of diseases that includes scrapie (found in sheep), bovine spongiform encephalopathy (BSE, found in cattle and commonly known as "Mad Cow Disease"), and variant Creutzfeldt-Jakob Disease (vCJD) in humans.

Although CWD remains under study, it is known to be invariably fatal to certain species of cervids, and is transmitted both directly (through animal-to-animal contact) and indirectly (through environmental contamination). To date there are no known cases where humans have been infected with CWD from consuming venison from infected deer. However, recent research suggests that CWD transmission from animals to humans through consumption of infected meat should not be ruled out. If CWD is not contained and controlled, the implications of the disease for Texas and its multi-billion-dollar ranching, hunting, wildlife management, and real estate economies could potentially be significant.

Since mid-July of this year, the department has received confirmation of CWD in deer breeding facilities in Brooks, Frio, Zavala, Kimble, and Cherokee counties. Current rules provide that when CWD is detected in a breeding facility or at a location where breeder deer have been released, the facility and any directly connected facilities are immediately prohibited from receiving or transferring deer and the department and Texas Animal Health Commission (TAHC) staff immediately begin epidemiological investigations to determine the extent and significance of possible disease transmission.

In the case of the Brooks County breeding facility, department records indicate that the facility has within the last five years transferred 1,057 deer to 51 deer breeding facilities, five Deer Management Permit (DMP) sites, and 77 release sites located in a total of 67 counties, as well as to three destinations in Mexico. In the case of the Frio County breeding facility, department records indicate that the facility has "certified herd" status under the TAHC herd certification program and within the last five years has transferred 627 deer to 46 deer breeding facilities, two nursing facilities, two DMP sites, and 29 release sites located in a total of 41 counties. In the case of the Zavala County breeding facility, department records indicate that within the last five years

the facility has transferred 276 deer to three deer breeding facilities, one DMP facility, and 21 release sites located in a total of 14 counties. In the case of the Kimble County breeding facility, the facility was the source or destination for 282 deer, including deer sent to seven release sites. In the case of the Cherokee County breeding facility, the facility received 17 deer from four breeding facilities but did not transfer deer to another breeding facility or release site. The breeding facilities, nursing facilities, DMP facilities, and release sites that have received deer from the positive facilities are directly connected to those facilities and are of epidemiological concern. These facilities are by current rule also prohibited from receiving or transferring deer unless and until epidemiological investigation determines that Movement Qualified (MQ) status can be restored. Deer breeding facilities that received deer from one or more of the directly connected breeding facilities (referred to as "Tier 1" facilities) are indirectly connected to the positive facilities and are of epidemiological concern because they have received exposed deer that were in a trace-out breeding facility.

The recent detections of CWD in breeding facilities located in Brooks, Frio, Zavala, Kimble, and Cherokee counties are part of an ongoing outbreak of CWD in deer breeding facilities. Since March 29, 2021, CWD has been detected in 15 counties. In 2023 alone, CWD has been detected in 12 deer breeding facilities located in nine counties. Prior to 2021, CWD was detected in six deer breeding facilities located in four counties.

In response to the magnitude and the potential severity of this situation, the emergency rules require the ante-mortem testing of test eligible deer prior to transfer from a breeding facility to another breeding facility.

The emergency action is necessary to protect the state's white-tailed deer populations, as well as associated industries.

The rule is adopted on an emergency basis under Parks and Wildlife Code, §12.027, which authorizes the department's executive director to adopt emergency rules if there is an immediate danger to a species authorized to be regulated by the department, Parks and Wildlife Code, Subchapter 43, Subchapter L, which authorizes the commission to make regulations governing the possession of breeder deer, reporting requirements, and procedures and requirements for the purchase, transfer, sale, or shipment of breeder deer; and under Government Code §2001.034, which authorizes a state agency to adopt such emergency rules without prior notice or hearing.

§65.95. Movement of Breeder Deer.

(a) General. Except as otherwise provided in this division, a breeding facility may transfer breeder deer under a transfer permit that has been activated and approved by the department to:

(1) another breeding facility as provided in subsection (b) of this section;

(2) an approved release site as provided in subsection (c) [~~(b)~~] of this section;

(3) - (4) (No change.)

(b) Transfer From Breeding Facility to Breeding Facility. A breeder deer may be transferred from one breeding facility to another breeding facility only if:

(1) an ante-mortem test on rectal or tonsil tissue collected from the deer within the eight months immediately preceding the transfer has been returned with test results of "not detected"; and

(2) the deer is at least six months of age at the time the test sample required by this paragraph is collected.

(3) An ante-mortem test result of "not detected" submitted to satisfy the requirements of §65.92(d) of this title (relating to CWD Testing) may be utilized a second time to satisfy the requirements of this subsection, provided the test sample was collected as provided in paragraph (1) of this subsection.

(4) A facility from which deer are transferred in violation of this subsection is automatically NMQ and any further transfers are prohibited until the permittee and the owner of the destination facility have complied with the testing requirements of the department, based on an epidemiological assessment as specified in writing.

(c) [~~(b)~~] Release Sites; Release of Breeder Deer.

(1) - (6) (No change.)

(d) [~~(c)~~] Trace-out Release Site.

(1) - (3) (No change.)

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304340
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: November 20, 2023
Expiration date: January 18, 2024
For further information, please call: (512) 389-4775

♦ ♦ ♦

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 353. MEDICAID MANAGED CARE

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §353.2, §353.4

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §353.2, concerning Definitions; and §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers.

BACKGROUND AND PURPOSE

The purpose of the proposed amendment to §353.4 is to require Medicaid health care managed care organizations (MCOs) to reimburse an out-of-network physician for providing Medicaid telemedicine medical services to a child in a primary or secondary school-based setting without prior authorization, even if the physician is not the child's primary care provider. This requirement is in accordance with Texas Government Code §531.0217(c-4) and is currently implemented through contracts between health care MCOs and HHSC. Texas Government Code §531.0217(c-4) was added by House Bill 1878, 84th Legislature, Regular Session, 2015, and amended by Senate Bill 670, 86th Legislature, Regular Session, 2019.

The proposed amendment to §353.2 adds definitions of "nursing facility," "nursing facility add-on services," "nursing facility services," and "nursing facility unit rate." The proposed amendment also removes a definition not used in the chapter.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.2 adds the definitions for "Nursing facility," "Nursing facility add-on services," "Nursing facility services," and "Nursing facility unit rate" to provide definitions of terms used in §353.4 and to align the definitions with language in managed care contracts. The proposed amendment removes the definition for "Main dental home provider" because this term is not used in the chapter.

The proposed amendment to §353.4 adds paragraph (3) to subsection (b) to include requirements for health care MCOs to reimburse out-of-network physicians for delivering a telemedicine medical service to a child in a primary or secondary school-based setting, even if the physician is not the child's primary care provider. The proposed amendment to add paragraph (3) to subsection (b) implements Texas Government Code §531.0217(c-4) and further aligns rule language with language in managed care contracts.

The proposed amendment to §353.4 reformats paragraph (1) of subsection (f) so that subparagraph (A) provides out-of-network nursing facilities that are located within the MCO's service area must be reimbursed at or above 95 percent of the nursing facility unit rate and subparagraph (B) provides out-of-network nursing facilities that are located outside of the MCO's service area must be reimbursed at or above 100 percent of the nursing facility unit rate. The proposed amendment also removes existing language in subparagraph (B) from paragraph (1) of subsection (f) as that language pertains to the definition of nursing facility unit rates, which is now defined in paragraph (77) of §353.2.

The proposed amendments to §353.2 and §353.4 also reformat the rules as necessary and make minor editorial changes.

FISCAL NOTE

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

MCOs are currently contractually required to reimburse an out-of-network physician providing school-based telemedicine medical services. Therefore, HHSC will not be required to adjust the MCO capitation payment.

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 existing rules;

(7) the proposed rules will not change the number of individuals subject to the rule(s); 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 to comply with the proposed rules. The rules only

apply to Medicaid MCOs and no Texas Medicaid MCO qualifies as a small business, micro-business, or rural community.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit will be more clarity about what is required of health care MCOs regarding reimbursement for out-of-network physicians who provide telemedicine medical services in school-based settings.

Trey Wood has also determined that for the first five years the rules are in effect, there are no expected economic costs for those required to comply because there are no requirements to alter current business practices and there are no new fees or costs imposed on a health care MCO.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R038" in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules as necessary to carry out the commission's duties; Human Resources Code §32.021 and Texas Government Code §531.021(a), which authorize HHSC to administer the federal medical assistance (Medicaid) program; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

§353.2. Definitions.

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

(1) Action--

(A) An action is defined as:

(i) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the failure to provide services in a timely manner;

(iv) the denial in whole or in part of payment for a service; or

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Texas Health and Human Services Commission (HHSC) and state and federal law.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Adoption Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter H (relating to Adoption Assistance Program).

(5) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(6) Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.

(7) Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

(8) Applicant Provider--A physician or other health care provider applying for expedited credentialing as defined in Texas Government Code §533.0064.

(9) Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

(10) Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.

(11) Capitation rate--A fixed predetermined fee paid by HHSC to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.

(12) CFR--Code of Federal Regulations.

(13) Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.

(14) Clean claim--A claim submitted by a physician or provider for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as further defined under the terms of the contract executed between the MCO and HHSC.

(15) Client--Any Medicaid-eligible recipient.

(16) CMS--The Centers for Medicare & Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

(17) Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.

(18) Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

(19) Consumer Directed Services (CDS) option--A service delivery option (also known as self-directed model with service budget) in which an individual or legally authorized representative employs and retains service providers and directs the delivery of certain program services.

(20) Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:

(A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and

(B) all value-added services under such contract.

(21) Credentialing--The process through which an MCO collects, assesses, and validates qualifications and other relevant information pertaining to a Medicaid enrolled health care provider to determine whether the provider may be contracted to deliver covered services as part of the network of the managed care organization.

(22) Cultural competency--The ability of individuals and systems to provide services effectively to people of various disabilities, cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

(23) Day--A calendar day, unless specified otherwise.

(24) Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.

(25) Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.

(26) Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.

(27) Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

(28) Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter, "dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.

(29) DFPS--The Texas Department of Family and Protective Services.

(30) Disability--A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, socializing, or working.

(31) Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

(32) Dual eligible--A Medicaid recipient who is also eligible for Medicare.

(33) Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.

(34) Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or

(B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

(35) Emergency medical condition--A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) serious jeopardy to the health of a pregnant woman or her unborn child.

(36) Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services.

(37) Encounter--A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services.

(38) Enrollment--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(39) EPSDT--The federally mandated Early and Periodic Screening, Diagnosis, and Treatment program defined in 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment). The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(40) EPSDT-CCP--The Early and Periodic Screening, Diagnosis, and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(41) Exclusive provider benefit plan (EPBP)--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(42) Expedited Credentialing--The process under Texas Government Code §533.0064 in which an MCO allows an applicant provider to provide Medicaid services to members on a provisional basis pending completion of the credentialing process.

(43) Experience rebate--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(44) Fair hearing--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(45) Federal Poverty Level (FPL)--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(46) Federal waiver--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(47) Federally Qualified Health Center (FQHC)--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(48) Former Foster Care Children (FFCC) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS, administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).

(49) Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(50) Habilitation--Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(51) Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(52) Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(53) Health care provider group--A legal entity, such as a partnership, corporation, limited liability company, or professional association, enrolled in Medicaid, under which certified or licensed individual health care providers provide health care items or services.

(54) Health care services--The acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and outpatient services.

(55) Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance with Chapter 844 of the Texas Insurance Code.

(56) Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(57) Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(58) Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may, depending on the circumstances, include a parent, guardian, or managing conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. 435.923.

(59) Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based setting necessary to allow the member to remain in the most integrated setting possible. LTSS includes services provided under the Texas State Plan as well as services available to persons who qualify for STAR+PLUS Home and Community-Based Program services or Medicaid 1915(c) waiver services. LTSS available through an MCO in STAR+PLUS, STAR Health, and STAR Kids varies by program model.

~~[(60) Main dental home provider--See definition of "dental home" in this section.]~~

(60) [~~(61)~~] Main dentist--See definition of "dental home" in this section.

(61) [~~(62)~~] Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(62) [~~(63)~~] Managed care organization (MCO)--A dental MCO or a health care MCO.

(63) [~~(64)~~] Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(64) [~~(65)~~] Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials.

(65) [~~(66)~~] MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(66) [~~(67)~~] Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(67) [~~(68)~~] Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS, administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(68) [~~(69)~~] Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits, as defined in Chapters 358, 360, and 361, of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities, Medicaid Buy-In Program, and Medicaid Buy-In for Children Program).

(69) [~~(70)~~] Medical home--A PCP or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(70) [~~(71)~~] Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:

(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and

(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the member's medical need;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

(71) [~~(72)~~] Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(72) [~~(73)~~] Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(73) [~~(74)~~] Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(74) [~~(75)~~] Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(75) Nursing facility--As defined in §358.103 of this title (relating to Definitions) and 26 TAC §554.101 (relating to Definitions), an entity or institution, also called nursing home or skilled nursing facility, that provides organized and structured nursing care and services and is subject to licensure under Texas Health and Safety Code Chapter 242.

(76) Nursing facility add-on services--The types of services that are provided in a nursing facility setting by a nursing facility provider or another provider, but are not included in the nursing facility unit rate, including emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, augmentative

communication devices, tracheostomy care for youth under age 22, and ventilator care.

(77) Nursing facility services--The services included in the nursing facility unit rate, nursing facility Medicare coinsurance, and nursing facility add-on services.

(78) Nursing facility unit rate--The rate for the type of services included in the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as defined in 26 TAC §554.2601 (relating to Vendor Payment (Items and Services Included)), including room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility staff rate enhancements as described in §355.308 of this title (relating to Direct Care Staff Rate Component), and professional and general liability insurance add-on payments as described in §355.312 of this title (relating to Reimbursement Setting Methodology--Liability Insurance Costs). The nursing facility unit rate excludes nursing facility add-on services.

(79) [~~(76)~~] Outside regular business hours--As applied to FQHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(80) [~~(77)~~] Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(81) [~~(78)~~] Permanency Care Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter J, Division 2 (relating to Permanency Care Assistance Program).

(82) [~~(79)~~] Person-centered care--An approach to care that focuses on members as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment.

(83) [~~(80)~~] Person-centered planning--A documented service planning process that includes people chosen by the individual, is directed by the individual to the maximum extent possible, enables the individual to make choices and decisions, is timely and occurs at times and locations convenient to the individual, reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, offers choices to the individual regarding the services and supports they receive and from whom, includes a method for the individual to require updates to the plan, and records alternative settings that were considered by the individual.

(84) [~~(81)~~] Post-stabilization care service--A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

(85) [~~(82)~~] Primary care provider (PCP)--A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(86) [~~(83)~~] Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO's members.

(87) [~~(84)~~] Provider education program--Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

(88) [~~(85)~~] Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(89) [~~(86)~~] Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(90) [~~(87)~~] Rural Health Clinic (RHC)--An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1) of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

(91) [~~(88)~~] Service area--The counties included in any HHSC-defined service area as applicable to each MCO.

(92) [~~(89)~~] Significant traditional provider (STP)--A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

(93) [~~(90)~~] STAR--The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(94) [~~(91)~~] STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in DFPS conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

(95) [~~(92)~~] STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preventative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(96) [~~(93)~~] STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(97) [~~(94)~~] STAR+PLUS Home and Community-Based Services Program--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(98) [~~(95)~~] State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(99) [~~(96)~~] Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to

the SSA in Baltimore, which then notifies the states through the State Data Exchange (SDX).

(100) [~~(97)~~] Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.

(101) [~~(98)~~] Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

§353.4. Managed Care Organization Requirements Concerning Out-of-Network Providers.

(a) Network adequacy. HHSC is the state agency responsible for overseeing and monitoring the Medicaid managed care program. Each managed care organization (MCO) participating in the Medicaid managed care program must offer a network of providers that is sufficient to meet the needs of the Medicaid population who are MCO members. HHSC monitors MCO members' access to an adequate provider network through reports from the MCOs and complaints received from providers and members. Certain reporting requirements are discussed in subsection (g) of this section.

(b) MCO requirements concerning coverage for treatment of members by out-of-network providers for non-emergency services.

(1) Nursing facility services. A health care MCO must reimburse an out-of-network nursing facility for medically necessary services authorized by HHSC, using the reasonable reimbursement methodology in subsection (f) of this section. Nursing facility add-on services are considered "other authorized services" under paragraph (2) of this subsection, and are authorized by STAR+PLUS MCOs.

(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:

(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;

(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and

(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.

(3) School-based telemedicine medical services. If a telemedicine medical service provided by an out-of-network physician to a member in a primary or secondary school-based setting meets the conditions for reimbursement in §354.1432 of this title (relating to Telemedicine and Telehealth Benefits and Limitations), a health care MCO must reimburse the out-of-network physician without prior authorization, even if the physician is not the member's primary care provider. The MCO must use the reasonable reimbursement methodology described in subsection (f)(2) of this section to reimburse an out-of-network physician.

(c) MCO requirements concerning coverage for treatment of members by out-of-network providers for emergency services.

(1) An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services.

(2) Health care MCO requirements concerning emergency services.

(A) A health care MCO may not refuse to reimburse an out-of-network provider for post-stabilization care services provided as a result of the MCO's failure to authorize a timely transfer of a member.

(B) A health care MCO must allow its members to be treated by any emergency services provider for emergency services, and services to determine if an emergency condition exists. The health care MCO must pay for such services.

(C) A health care MCO must reimburse for transport provided by an ambulance provider for a Medicaid recipient whose condition meets the definition of an emergency medical condition. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in §353.2 of this subchapter (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

(D) A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

(3) Dental MCO requirements concerning emergency services.

(A) A dental MCO must allow its members to be treated for covered emergency services that are provided outside of a hospital or ambulatory surgical center setting, and for covered services provided outside of such settings to determine if an emergency condition exists. The dental MCO must pay for such services.

(B) A dental MCO is prohibited from requiring an authorization for the services described in subparagraph (A) of this paragraph.

(C) A dental MCO is not responsible for payment of non-capitated emergency services and post-stabilization care provided in a hospital or ambulatory surgical center setting, or devices for craniofacial anomalies. A dental MCO is not responsible for hospital and physician services, anesthesia, drugs related to treatment, and post-stabilization care for:

(i) a dislocated jaw, traumatic damage to a tooth, and removal of a cyst;

(ii) an oral abscess of tooth or gum origin; and

(iii) craniofacial anomalies.

(D) The services and benefits described in subparagraph (C) of this paragraph are reimbursed:

(i) by a health care MCO, if the member is enrolled in a managed care program; or

(ii) by HHSC's claims administrator, if the member is not enrolled in a managed care program.

(d) Health care MCO requirements concerning coverage for services provided to certain members by an out-of-network "specialty provider" as that term is defined in §353.7(c) of this subchapter (relating to Continuity of Care with Out-Of-Network Specialty Providers).

(1) A health care MCO may not refuse to reimburse an out-of-network "specialty provider" enrolled as a provider in the Texas Medicaid program for services provided to a member under the circumstances set forth in §353.7 of this subchapter.

(2) In reimbursing a provider for the services described in paragraph (1) of this subsection, a health care MCO must use the reasonable reimbursement methodology in subsection (f)(2) of this section.

(e) An MCO may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described in subsections (b) - (d) of this section.

(f) Reasonable reimbursement methodology.

(1) Out-of-network nursing facilities.

(A) Out-of-network nursing facilities must be reimbursed[:]

[(i)] at or above 95 [~~ninety-five~~] percent of the nursing facility unit rate established by HHSC for the dates of service for services provided inside of the MCO's service area. [~~; and~~]

(B) Out-of-network nursing facilities must be reimbursed

[(ii)] at or above 100 [~~one hundred~~] percent of the nursing facility unit rate for the dates [~~date~~] of services for services provided outside of the MCO's service area.

[~~(B) The nursing facility unit rate refers to the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as determined by HHSC. The rate includes items such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes professional and general liability insurance and applicable nursing facility rate enhancements. The nursing facility unit rate excludes nursing facility add-on services.~~]

(2) Emergency and authorized services performed by out-of-network providers.

(A) Except as provided in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (j)(2) of this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.

(B) Except as provided in §353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service, unless the parties agree to a different reimbursement amount, until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

(3) For purposes of this subsection, the Medicaid FFS rates are defined as those rates for providers of services in the Texas Medicaid program for which reimbursement methodologies are specified in Chapter 355 of this title (relating to Reimbursement Rates), exclusive of the rates and payment structures in Medicaid managed care.

(g) Reporting requirements.

(1) Each MCO that contracts with HHSC to provide health care services or dental services to members in a service area must submit quarterly information in its Out-of-Network quarterly report to HHSC.

(2) Each report submitted by an MCO must contain information about members enrolled in each HHSC Medicaid managed care program provided by the MCO. The report must include the following information:

(A) the types of services provided by out-of-network providers for the MCO's members;

(B) the scope of services provided by out-of-network providers to the MCO's members;

(C) for a health care MCO, the total number of hospital admissions, as well as the number of admissions that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(D) for a health care MCO, the total number of emergency room visits, as well as the total number of emergency room visits that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(E) total dollars for paid claims by MCOs, other than those described in subparagraphs (C) and (D) of this paragraph, as well as total dollars billed by out-of-network providers for other services; and

(F) any additional information required by HHSC.

(3) HHSC determines the specific form of the report described in this subsection and includes the report form as part of the Medicaid managed care contract between HHSC and the MCOs.

(h) Utilization.

(1) Upon review of the reports described in subsection (g) of this section that are submitted to HHSC by the MCOs, HHSC may determine that an MCO exceeded maximum out-of-network usage standards set by HHSC for out-of-network access to health care services and dental services during the reporting period.

(2) Out-of-network usage standards.

(A) Inpatient admissions: No more than 15 percent of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.

(B) Emergency room visits: No more than 20 percent of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.

(C) Other services: For services that are not included in subparagraph (A) or (B) of this paragraph, no more than 20 percent of total dollars for paid claims by the MCO for services provided may be provided by out-of-network providers.

(3) Special considerations in calculating a health care MCO's out-of-network usage of inpatient admissions and emergency room visits.

(A) In the event that a health care MCO exceeds the maximum out-of-network usage standard set by HHSC for inpatient admissions or emergency room visits, HHSC may modify the calculation of that health care MCO's out-of-network usage for that standard if:

(i) the admissions or visits to a single out-of-network facility account for 25 percent or more of the health care MCO's admissions or visits in a reporting period; and

(ii) HHSC determines that the health care MCO has made all reasonable efforts to contract with that out-of-network facility as a network provider without success.

(B) In determining whether the health care MCO has made all reasonable efforts to contract with the single out-of-network facility described in subparagraph (A) of this paragraph, HHSC considers at least the following information:

(i) how long the health care MCO has been trying to negotiate a contract with the out-of-network facility;

(ii) the in-network payment rates the health care MCO has offered to the out-of-network facility;

(iii) the other, non-financial contractual terms the health care MCO has offered to the out-of-network facility, particularly those relating to prior authorization and other utilization management policies and procedures;

(iv) the health care MCO's history with respect to claims payment timeliness, overturned claims denials, and provider complaints;

(v) the health care MCO's solvency status; and

(vi) the out-of-network facility's reasons for not contracting with the health care MCO.

(C) If the conditions described in subparagraph (A) of this paragraph are met, HHSC may modify the calculation of the health care MCO's out-of-network usage for the relevant reporting period and standard by excluding from the calculation the inpatient admissions or emergency room visits to that single out-of-network facility.

(i) Provider complaints.

(1) HHSC accepts provider complaints regarding reimbursement for or overuse of out-of-network providers and conducts investigations into any such complaints.

(2) When a provider files a complaint regarding out-of-network payment, HHSC requires the relevant MCO to submit data to support its position on the adequacy of the payment to the provider. The data includes a copy of the claim for services rendered and an explanation of the amount paid and of any amounts denied.

(3) Not later than the 60th day after HHSC receives a provider complaint, HHSC notifies the provider who initiated the complaint of the conclusions of HHSC's investigation regarding the complaint. The notification to the complaining provider includes:

(A) a description of the corrective actions, if any, required of the MCO in order to resolve the complaint; and

(B) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

(4) If HHSC determines through investigation that an MCO did not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) of this section, HHSC initiates a corrective action plan. Refer to subsection (j) of this section for information about the contents of the corrective action plan.

(5) If, after an investigation, HHSC determines that additional reimbursement is owed to an out-of-network provider, the MCO must:

(A) pay the additional reimbursement owed to the out-of-network provider within 90 days from the date the complaint was received by HHSC or 30 days from the date the clean claim, or information required that makes the claim clean, is received by the MCO, whichever comes first; or

(B) submit a reimbursement payment plan to the out-of-network provider within 90 days from the date the complaint was received by HHSC. The reimbursement payment plan provided by the MCO must provide for the entire amount of the additional reimbursement to be paid within 120 days from the date the complaint was received by HHSC.

(6) If the MCO does not pay the entire amount of the additional reimbursement within 90 days from the date the complaint was received by HHSC, HHSC may require the MCO to pay interest on the unpaid amount. If required by HHSC, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the complaint was received by HHSC, until the date the entire amount of the additional reimbursement is paid.

(7) HHSC pursues any appropriate remedy authorized in the contract between the MCO and HHSC if the MCO fails to comply with a corrective action plan under subsection (j) of this section.

(j) Corrective action plan.

(1) HHSC requires a corrective action plan in the following situations:

(A) the MCO exceeds a maximum standard established by HHSC for out-of-network access to health care services and dental services described in subsection (h) of this section; or

(B) the MCO does not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) of this section.

(2) A corrective action plan imposed by HHSC requires one of the following:

(A) reimbursements by the MCO to out-of-network providers at rates that equal the allowable rates for the health care services as determined under §32.028 and §32.0281, Texas Human Resources Code, for all health care services provided during the period:

(i) the MCO is not in compliance with a utilization standard established by HHSC; or

(ii) the MCO is not reimbursing out-of-network providers based on a reasonable reimbursement methodology, as described in subsection (f) of this section;

(B) initiation of an immediate freeze by HHSC on the enrollment of additional recipients in the MCO's managed care plan until HHSC determines that the provider network under the managed care plan can adequately meet the needs of the additional recipients;

(C) education by the MCO of members enrolled in the MCO regarding the proper use of the MCO's provider network; or

(D) any other actions HHSC determines are necessary to ensure that Medicaid recipients enrolled in managed care plans provided by the MCO have access to appropriate health care services or dental services, and that providers are properly reimbursed by the MCO for providing medically necessary health care services or dental services to those recipients.

(k) Application to Pharmacy Providers. The requirements of this section do not apply to providers of outpatient pharmacy benefits, except as noted in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services).

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304327

Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 221-6857

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 417. AGENCY AND FACILITY RESPONSIBILITIES

SUBCHAPTER A. STANDARD OPERATING PROCEDURES

25 TAC §§417.47, 417.49, 417.50

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes the repeal of §417.47, concerning Training Requirements for State Mental Health Facilities; §417.49, concerning References; and concerning §417.50, Distribution.

BACKGROUND AND PURPOSE

The purpose of the proposed repeals is to reflect the move of the state hospitals from the Department of State Health Services (DSHS) to HHSC by moving HHSC rules from Texas Administrative Code (TAC) Title 25, Chapter 417, Subchapter A to 26 TAC Chapter 926 and consolidate HHSC rules. These rules will be repealed, updated, and placed in 26 TAC Chapter 926. The new rules are proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

The repeal of the rules in 25 TAC Chapter 417, Subchapter A will delete the rules from 25 TAC and place updated rules in 26 TAC to reflect the transfer of functions from DSHS to HHSC.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the repeals will be in effect, enforcing or administering the repeals 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 repeals will be in effect:

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

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

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

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

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

(6) the proposed repeals will repeal existing rules;

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

(8) the proposed repeals 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 because the repeals do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed repeals will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the repeals are in effect, the public benefit will be the removal of rules no longer associated with DSHS from 25 TAC.

Trey Wood has also determined that for the first five years the repeals are in effect, there are no anticipated economic costs to persons who are required to comply with the repeals because the repeals do not impose a cost.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Health and Safety Code §552.052, which requires HHSC to provide certain training for employees of State Hospitals and requires the Executive Commissioner to adopt rules to require State Hospitals to provide refresher training courses to employees.

The repeals affect Texas Government Code §531.0055 and Texas Health and Safety Code §552.052.

§417.47. Training Requirements for State Mental Health Facilities.
§417.49. References.
§417.50. Distribution.

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
Department of State Health Services
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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 338. DISASTER RULE FLEXIBILITIES FOR LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES (LIDDAs)

26 TAC §338.1

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes in Title 26, Texas Administrative Code (TAC), new Chapter 338, Disaster Rule Flexibilities for Local Intellectual and Developmental Disability Authorities (LIDDAs), comprising of §338.1, concerning Disaster Flexibilities.

BACKGROUND AND PURPOSE

The purpose of the proposal is to add a new chapter and rule to allow LIDDAs to use certain flexibilities to certain rules when providing services during a declared disaster under Texas Government Code §418.014.

LIDDAs provide essential services to individuals with intellectual or developmental disabilities (IDD). This vulnerable population relies on LIDDA staff to assist them in securing the services they need, achieving their desired outcomes and best quality of life. Disaster rule flexibilities for LIDDAs ensure that when a disaster declaration is in effect, HHSC may issue timely guidance and authorize flexibilities for LIDDAs to provide services.

The proposal creates a standing rule allowing HHSC to notify LIDDAs of certain flexibilities immediately upon a disaster declaration. These flexibilities include allowing service coordination to be delivered via audio-only or audio-visual communication to ensure continuity of services, as well as extending some timeframes for LIDDAs. In addition, the proposal requires that LIDDAs follow HHSC guidance related to the rules, comply with all applicable requirements related to security and privacy of information, and notify persons impacted by the flexibilities, if applicable.

SECTION-BY-SECTION SUMMARY

Proposed new §338.1(a) establishes definitions for terminology used in this chapter, including "audio-only," "audio-visual," "face-to-face," and "in-person (or in person)."

Proposed new §338.1(b) establishes that in the event of a declared state of disaster, HHSC may allow flexibilities described in subsection (c). HHSC will notify LIDDAs of the beginning and end dates for rule flexibilities.

Proposed new §338.1(c) identifies the rules for which HHSC will allow flexibilities to the extent authorized under federal and state law, including a flexibility to 26 TAC §331.11(d) that allows LIDDAs to provide service coordination using audio-visual or audio-only communication instead of in person. Additionally, HHSC may allow flexibilities to certain rules that set forth timeframes applicable to the LIDDAs by extending the timeframes.

Proposed new §338.1(d) requires LIDDAs that use the flexibilities to comply with all guidance on the application of the rules identified in subsection (c) published by HHSC, including policy guidance issued by HHSC's Community Services Division and Medicaid and CHIP Services.

Proposed new §338.1(e) requires that LIDDAs ensure audio-only or audio-visual communication complies with all applicable requirements related to security and privacy of information.

Proposed new §338.1(f) requires LIDDAs to notify persons receiving services, or other individuals, as applicable, of the extensions to the timeframes permitted under subsection (c)(2).

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will create a new rule;

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

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

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

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

Trey Wood has also determined that there is no adverse economic effect on small businesses, micro-businesses, or rural communities. The proposed rule provides certain flexibilities for LIDDAs during a declared disaster, but there is no requirement to alter current business practices. No rural communities contract

with HHSC in any program or service affected by the proposed rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect the local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule is necessary to protect the health, safety, and welfare of the residents of Texas; does not impose a cost on regulated persons; and is proposed to reduce the burden or responsibilities imposed on regulated persons by the rule.

PUBLIC BENEFIT AND COSTS

Haley Turner, Deputy Executive Commissioner for Community Services, has determined that for each year of the first five years the rule is in effect, the public benefit will be the continuity of services to vulnerable Texans during declared disasters.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because there is no requirement to alter current business practices. LIDDAs are not required to utilize HHSC-authorized flexibilities during declared disasters.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R019" in the subject line.

STATUTORY AUTHORITY

The new section is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; Texas Human Resources Code §32.021, which provides that HHSC will adopt necessary rules for the proper and efficient administration of the Medicaid program; and Texas Health & Safety Code §533A.0355(a), which provides that the Executive Commissioner of HHSC shall adopt rules establishing the roles and responsibilities of LIDDAs.

The new section affects Texas Government Code §§531.0055 and 531.021, Texas Human Resources Code §32.021, and Texas Health & Safety Code §533A.0355(a).

§338.1. Disaster Flexibilities.

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

(1) Audio-only--An interactive, two-way audio communication that uses only sound and that meets the privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include face-to-face communication.

(2) Audio-visual--An interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audio-visual does not include audio-only or in-person communication.

(3) Face-to-face--In-person or audio-visual communication that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include audio-only communication.

(4) In-person (or in person)--Within the physical presence of another person. In-person or in person does not include audio-visual or audio-only communication.

(b) The Texas Health and Human Services Commission (HHSC) may allow local intellectual and developmental disability authorities (LIDDAs) to use the flexibilities described in subsection (c) of this section while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. HHSC will notify LIDDAs when a flexibility is permitted and the date the flexibility must no longer be used, which may be before the declaration of a state of disaster expires.

(c) Subject to the notification by HHSC, the following flexibilities may be available to LIDDAs to the extent the flexibility is permitted by and does not conflict with other laws or obligations of the LIDDA and is allowed by federal and state law.

(1) Service coordination required to be provided in person under 26 TAC §331.11(d) of this title (relating to LIDDA's Responsibilities) may be provided using audio-visual or audio-only communication.

(2) HHSC may extend the timeframes for LIDDAs in the following rules:

(A) the timeframe to request an administrative hearing in 40 TAC §4.156 (relating to Request for an Administrative Hearing);

(B) the timeframe for a person and legally authorized representative (LAR) to request a review of a decision to deny or terminate services in 40 TAC §2.46(e)(3) (relating to Notification and Appeals Process);

(C) the timeframe for a person or the person's parent to comply with the applicable accountability requirement in 40 TAC §2.105(f)(1) (relating to Accountability)in order for the LIDDA to retroactively adjust the person's account; and

(D) the timeframe for a person or parent to submit a request to review a LIDDA's appeal decision to HHSC in 40 TAC §2.109(e)(3) (relating to Payments, Collections, and Non-payment).

(d) LIDDAs that use one or more of the flexibilities allowed under subsection (c) of this section must comply with:

(1) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Community Services Division during the declaration of disaster that is published by HHSC on its LIDDA website or in another communication format HHSC determines appropriate; and

(2) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Medicaid and CHIP Services.

(e) LIDDAs must ensure audio-only or audio-visual communication complies with all applicable requirements related to security and privacy of information.

(f) LIDDAs must notify the person, the LAR, or the person's parent if the person is younger than 18 years of age, of the extension of timeframes permitted under subsection (c)(2) of this section that apply to the person receiving services.

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

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-5609

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CHAPTER 745. LICENSING
SUBCHAPTER G. CONTROLLING PERSONS

26 TAC §§745.901, 745.903 - 745.905

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §745.901, concerning Who is a controlling person at a child-care operation, §745.903, concerning When and how must an operation submit controlling-person information to Licensing, and §745.905, concerning When will Licensing designate someone at my child-care operation as a controlling person; and new §745.904, concerning What must I do to verify the accuracy of the list of controlling persons associated with my operation, in Texas Administrative Code, Title 26, Chapter 745, Licensing, Subchapter G, Controlling Persons.

BACKGROUND AND PURPOSE

The purpose of this proposal is to adopt rules in Chapter 745 to implement HHSC Child Care Regulation's (CCR) Performance Management Unit (PMU) recommendations from the Fiscal Year (FY) 2019 and FY 2021 reports: Annual Casereading, Read-Behind, and Field Assessment. In these reports, PMU recommended IT enhancements to support a change in current business practice related to verifying an operation's controlling persons list. The current practice requires CCR inspectors to verify an operation's controlling persons list during all monitoring inspections. PMU recommended CCR change to a new practice that would require an operation to validate the controlling persons list on a scheduled basis using the operation's online Child Care Regulation Account.

The IT enhancements, and consequently the rules, also support implementation of Texas Human Resources Code (HRC) §42.025(b)(4) and (c), which were added by Senate Bill 225, 87th Legislature, Regular Session, 2021. HRC §42.025(b)(4) and (c) require CCR to list certain information for child-care homes and listed family homes on the Search Texas Child Care website regarding involuntary suspensions, revocations, and refusals to renew permits.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §745.901 (1) reorganizes a subdivision of the rule to improve readability; (2) adds language to clarify that a child-care home includes a licensed or registered child-care home; and (3) adds the primary caregiver of a listed family home and the caregiver's spouse to the definition of a controlling person.

The proposed amendment to §745.903 (1) updates language and punctuation to improve readability; (2) updates a reference; and (3) updates language to reflect that a child-care operation may submit controlling person information online through the operation's Child Care Regulation Account, not the DFPS website.

Proposed new §745.904 outlines what a child-care operation must do to verify the accuracy of the operation's controlling persons list by requiring a child-care operation to validate the controlling persons list, including each person's role at the operation, on a scheduled basis and prescribing the way the operation must complete the validation. The rule requires (1) a School-Age and Before or After-School Program, Licensed Child-Care Center, General Residential Operation, and Child-Placing Agency to validate the accuracy of the list quarterly and make necessary corrections via the child-care operation's online Child Care Regulation Account; (2) a Licensed Child-Care Home and Registered Child-Care Home to validate the accuracy of the list annually and make necessary corrections via the child-care home's online Child Care Regulation Account; and (3) a Listed Family Home to validate the accuracy of the list annually and make necessary corrections via the home's online Child Care Regulation Account or by contacting the local Child Care Regulation office.

The proposed amendment to §745.905 (1) updates a reference; (2) updates language to improve readability; (3) corrects an inaccurate pronoun usage; and (4) removes language that implies a Controlling Person Form is the only way an operation may submit controlling person information.

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. All costs related to IT enhancements will be absorbed with existing resources.

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 a government program;

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

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

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

(5) the proposed rules will create 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 because the rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Associate Commissioner for Child Care Regulation, has determined that for each year of the first five years the rules are in effect, the public will benefit through improved safety of children in out of home care as a result of more timely and accurate accounting of the controlling persons associated with a child-care operation and rules that support a change to business practice.

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. The controlling persons validation requirements can be implemented by each child-care operation's existing administrative processes and do not require additional staff.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Aimee Belden by email at Aimee.Belden@hhs.texas.gov.

Written comments on the proposal may be submitted to Aimee Belden, Rules Writer, Child Care Regulation, Texas Health and Human Services Commission, E-550, P.O. Box 149030, Austin, Texas 78714-9030; or by email to CCRRules@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R016" in the subject line.

STATUTORY AUTHORITY

The amendments and new section are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.02011, which transferred the regulatory functions of the Department of Family and Protective Services to HHSC. In addition, HRC §42.042(a) requires HHSC to adopt rules to carry out the requirements of Chapter 42 of HRC.

The amendments and new section affect Texas Government Code §531.0055 and HRC §42.042.

§745.901. Who is a controlling person at a child-care operation?

(a) A controlling person of a child-care operation is any:

(1) Owner of the operation or member of the governing body of the operation, including, as applicable: [~~,~~]

(A) An [~~an~~] executive, an officer, or a board member; [~~,~~]

(B) A [~~a~~] partner;[~~,~~]

(C) A [~~a~~] sole proprietor and the sole proprietor's spouse; [~~,~~] or

(D) The [~~the~~] primary caregiver at a licensed child-care home, registered child-care home, or listed family home and the primary caregiver's spouse;

(2) Person who manages, administrates, or directs the operation or its governing body, including a day care director or a licensed administrator; or

(3) Person who either alone or in connection with others has the ability to influence or direct the management, expenditures, or policies of the operation. For example, a person may have influence over the operation because of a personal, familial, or other relationship with the governing body, manager, or other controlling person of the operation.

(b) A person does not have to be present at the operation or hold an official title at the operation or governing body in order to be a controlling person.

(c) An employee, lender, secured creditor, or landlord of the operation is not a controlling person unless the person meets a definition in subsection (a) of this section.

§745.903. When and how must I [~~an operation~~] submit controlling person [~~controlling person~~] information to Licensing?

(a) You must provide information about each person that is a controlling person at your operation as defined in §745.901(a) of this subchapter [~~title~~] (relating to Who is a controlling person at a child-care operation?) when you apply for your permit.

(b) After you receive a permit from us, you must provide us information about someone who is a controlling person at your operation within two days after a person becomes a controlling person.

(c) To provide the information to us, you must either:

(1) Enter the information online [~~on-line~~] through your Child Care Regulation Account [~~the DFPS website~~]; or

(2) Submit a completed Controlling Person Form to your local Child Care Regulation [~~Licensing~~] office.

§745.904. What must I do to verify the accuracy of the list of controlling persons associated with my operation?

You must validate the accuracy of your controlling persons list, including each person's role at your operation, and make any necessary corrections:

(1) Every three months through your online Child Care Regulation Account for:

(A) School-Age or Before or After-School Programs;

(B) Licensed Child-Care Centers;

(C) General Residential Operations; and

(D) Child-Placing Agencies;

(2) Once a year through your online Child Care Regulation Account for:

(A) Licensed Child-Care Homes; and

(B) Registered Child-Care Homes; and

(3) Once a year for Listed Family Homes:

(A) Through your online Child Care Regulation Account; or

(B) By contacting the local Child Care Regulation office.

§745.905. When will Licensing designate someone at my child-care operation as a controlling person?

(a) We will designate each person who meets the definition of a controlling person in §745.901(a) of this subchapter [~~title~~] (relating to Who is a controlling person at a child-care operation?) as a controlling person at your operation when:

(1) We revoke your permit; or

(2) You voluntarily close your operation or relinquish your permit after you receive notice of our intent to revoke your permit or that we are revoking your permit.

(b) We may designate a person at your operation as a controlling person, regardless of whether you submitted the person's [~~their~~] name as a controlling person at your child-care operation [~~on a Controlling Person Form~~].

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

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304342
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 438-3269

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CHAPTER 926. TRAINING FOR FACILITY STAFF

26 TAC §§926.1 - 926.6

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §926.1, concerning Application; §926.2, concerning Definitions; concerning §926.3, concerning Training for New Employees; §926.4, concerning Additional Training for Employees who Provide Direct Care to Individuals; §926.5, concerning State Hospital Refresher Training; and §926.6, concerning State Supported Living Center (SSLC) Refresher Training.

BACKGROUND AND PURPOSE

The purpose of the proposed new rules is to reflect the move of the state hospitals from the Department of State Health Services and the state supported living centers from the Department of Aging and Disability Services to HHSC. HHSC is moving several rules from Title 25 of the Texas Administrative Code (TAC), Chapter 417, Subchapter A and 40 TAC Chapter 3, Subchapter D, Training, and consolidating rules under 26 TAC Chapter 926. The proposed rules update agency information, provide uniform training topics and timeframes, and remove text regarding expedited training due to the COVID-19 disaster declaration. The repeal of certain rules from 25 TAC Chapter 417, Subchapter A and 40 TAC Chapter 3, Subchapter D is proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

Proposed new §926.1 establishes that the chapter applies to state hospitals in accordance with Texas Health and Safety Code §552.052 and state supported living centers in accordance with Texas Health and Safety Code §555.024.

Proposed new §926.2 provides the definition of certain terms used within the chapter.

Proposed new §926.3 outlines training provided to all new facility employees.

Proposed new §926.4 outlines additional training provided to facility employees who provide direct care.

Proposed new §926.5 outlines refresher training provided to state hospital employees.

Proposed new §926.6 outlines refresher training provided to SSLC employees.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new rules;

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

(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 proposed rules do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the rules are in effect, the public benefit will be consolidation of HHSC rules in 26 TAC, and improved general public access to requirements.

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 rules because the rule applies only to HHSC.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, Health and Safety Code §552.052, which requires HHSC to provide certain training to state hospital employees, and for the Executive Commissioner to adopt rules regarding refresher trainings for employees, and Texas Health and Safety Code §555.024, which requires HHSC to provide certain training to SSLC employees, and for the Executive Commissioner to adopt rules regarding refresher trainings for employees.

The new rules affect Texas Government Code §531.0055, and Texas Health and Safety Code §§552.052 and 555.024.

§926.1. Application.

This chapter applies to state hospitals in accordance with Texas Health and Safety Code (HSC) §552.052 and state supported living centers in accordance with Texas HSC §555.024.

§926.2. Definitions.

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

(1) Direct care employee--A facility employee who provides direct delivery of services to an individual.

(2) Facility--A state hospital or state supported living center.

(3) Individual--A person who is receiving services at a facility.

(4) State hospital--A hospital as defined under Texas Health and Safety Code (HSC) §552.0011 operated by the Texas Health and Human Services Commission (HHSC) primarily to provide inpatient care and treatment for individuals with mental illness.

(5) State supported living center (SSLC)--An SSLC as defined by Texas HSC §531.002 and the intermediate care facility for individuals with intellectual disabilities component of the Rio Grande State Center operated by HHSC.

§926.3. Training for New Employees.

Before an employee performs employment duties without direct supervision, the employee must receive competency-based training and instruction on general duties.

(1) The focus of training must be on:

(A) the uniqueness of the individuals with whom the employee works;

(B) techniques for improving quality of life for and promoting the health and safety of individuals; and

(C) the conduct expected of employees.

(2) The training must include instruction and information on:

(A) the general operation and layout of the facility at which the person is employed;

(B) armed intruder lockdown procedures;

(C) respecting personal choices made by individuals;

(D) the safe and proper use of restraints;

(E) recognizing and reporting:

(i) abuse, neglect, and exploitation of individuals;

(ii) unusual or reportable incidents;

(iii) reasonable suspicion of illegal drug use in the workplace;

(iv) workplace violence; and

(v) sexual harassment in the workplace;

(F) preventing and treating infection;

(G) responding to emergencies, including information about first aid and cardiopulmonary resuscitation procedures;

(H) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(I) the rights of employees;

(J) additional topics for state hospital employees, which include:

(i) an introduction to mental illness;

(ii) an introduction to substance use;

(iii) an introduction to dual diagnosis; and

(iv) the rights of individuals with mental illness;

(K) additional topics for state supported living center employees, which include:

(i) an introduction to intellectual disabilities;

(ii) an introduction to autism; and

(iii) an introduction to mental illness and dual diagnosis; and

(L) the rights of individuals with an intellectual or developmental disability, including the right to live in the least restrictive setting appropriate to the individual's needs and abilities.

§926.4. Additional Training for Employees who Provide Direct Care to Individuals.

(a) Before an employee who provides direct delivery of services begins to perform direct care duties without direct supervision, the facility must provide the employee relevant training essential to perform the employee's duties regarding implementation of the interdisciplinary treatment program for each individual for whom the employee will provide direct care, including the following topics:

(1) prevention and management of aggressive or violent behavior;

(2) observing and reporting changes in behavior, appearance, or health of an individual;

(3) positive behavior support;

(4) emergency response;

(5) person-directed plans;

(6) self-determination; and

(7) trauma-informed care.

(b) Facilities must provide training on the following topics relevant to the individuals the direct care employee will serve:

(1) techniques for lifting, positioning, moving and increasing mobility;

(2) specialized needs of geriatric individuals;

(3) assisting individuals with visual, hearing, or communication impairments or who require adaptive devices and specialized equipment;

(4) recognizing appropriate food textures;

(5) using proper feeding techniques to assist individuals with meals;

(6) specific to state supported living center direct care employees:

(A) seizure safety;

(B) working with aging individuals;

(C) assisting individuals with personal hygiene;

(D) physical and nutritional management plans;

(E) home and community-based services, including the principles of community inclusion and participation and the community living options information process; and

(F) procedures for securing evidence following an incident of suspected abuse, neglect, or exploitation; and

(7) specific to state hospital direct care employees:

(A) seizure safety;

(B) assisting patients with personal hygiene; and

(C) physical and nutritional management plans.

§926.5. State Hospital Refresher Training.

State hospitals must provide all employees annual training relevant to their position on the topics outlined in §926.3 of this chapter (relating to Training for New Employees) and §926.4 of this chapter (relating to Additional Training for Employees who Provide Direct Care to Individuals), as the topics pertain to state hospital employees. State hospitals must provide this training throughout an employee's employment or association with the state hospital, unless the agency determines in good faith and with good reason a particular employee's performance will not be adversely affected in the absence of such refresher training.

§926.6. State Supported Living Center (SSLC) Refresher Training.

(a) An SSLC must provide employees annual training on:

(1) abuse, neglect, and exploitation; and

(2) unusual incidents.

(b) An SSLC must provide training to employees who are not direct care employees on the rights of individuals every two years.

(c) An SSLC must provide all direct care employees annual training relevant to their position on the topics outlined in §926.3 of this chapter (relating to Training for New Employees) and §926.4 of this chapter (relating to Additional Training for Employees who Provide Direct Care to Individuals), unless otherwise addressed in this section, as the topics pertain to SSLC employees.

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304328
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 438-3049

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

The Texas Department of Insurance (TDI) proposes to amend §3.3038 in Subchapter S of 28 TAC Chapter 3; §§3.3702 - 3.3705 and 3.3707 - 3.3711 in Subchapter X, Division 1, of 28 TAC Chapter 3; and §§3.3720, 3,3722, and 3.3723 in Subchapter X, Division 2, of 28 TAC Chapter 3. TDI also proposes new §3.3712 and §3.3713 in Subchapter X, Division 1; proposes to repeal §3.3725 in Subchapter X, Division 2; and proposes to amend the title of Subchapter X, Division 2. These sections concern preferred and exclusive provider benefit plans. Among other changes, the repeal, amendments, and new sections implement House Bills 711, 1647, 1696, 2002, and 3359, 88th Legislature, 2023; Senate Bill 1264, 86th Legislature, 2019; and Senate Bills 1003 and 2476, 88th Legislature, 2023, and address the court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance,* Travis County District Court No. D-1-GN-18-003846 (October 15, 2020) (TAHP Order), which invalidated 28 TAC §§3.3708(a), 3.3708(b)(1), 3.3708(b)(3), 3.3725(d), and 11.1611(d).

EXPLANATION. This proposal implements HB 711, which prohibits anticompetitive contract provisions; HB 1647, which provides protections for certain clinician-administered drugs; HB 1696, which expands protections for optometrists and therapeutic optometrists in contracts with managed care plans; HB 2002, which requires insurers to credit certain out-of-network payments to the enrollee's deductible and maximum out-of-pocket amounts; HB 3359, which provides extensive network adequacy standards and requirements; SB 1003, which expands facility-based provider types that must be listed in provider directories; and SB 2476, which creates new payment standards and balance billing protections for emergency medical services.

The proposal makes additional amendments in Subchapter S and throughout Subchapter X. The proposed amendments remove payment rules that were invalidated by court order, provide new payment requirements and protections for preferred and exclusive provider plans consistent with SB 1264, expand exceptions to guaranteed renewability requirements, affirm TDI's prohibition on referral requirements, prohibit penalties on insureds for failure to obtain a preauthorization, restrict misrepresentation of cost-sharing incentives in advertisements, streamline disclosure requirements for policy terms, require that certain filings be submitted to TDI via the National Association of Insurance Commissioners' System for Electronic Rate and Form Filings (SERFF) instead of email, remove references to a repealed section, and revise sections as necessary to conform to changes in other sections. A proposed amendment revises the title of Subchapter X, Division 2, to reflect that the division addresses application, examination, and plan requirements and applies to both preferred and exclusive provider benefit plans.

HB 3359 applies to policies delivered, issued for delivery, or renewed on or after September 1, 2024. Insurance Code §1301.0056 requires TDI to examine network adequacy before a plan is offered, and Insurance Code §1301.00565 requires TDI to hold a public hearing before approving a waiver request. To ensure adequate time for network adequacy reviews and waiver hearings, TDI will begin reviewing networks according to the new standards in advance of September 1, 2024. The proposed rules will apply to annual network adequacy reports due by April 1, 2024, and any network configuration filings made after that date. A network that will not be used with any plan issued or renewed on or after September 1, 2024, will continue to be subject to the rules in effect at the time the plan was issued or renewed.

The proposed repeal, amendments, and new sections are described in the following paragraphs.

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions. The proposed amendments to §3.3038 expand the exceptions related to guaranteed renewability to permit coverage under a preferred or exclusive provider benefit plan to be discontinued or nonrenewed if the insured no longer resides, lives, or works in the service area of the issuer by removing a reference to subsection (c) of the section in subsection (a) and amending subsection (c)(4) to include Insurance Code Chapter 1301 and adding references to the insurer's service area to subsections (c), (e), and (f). These changes implement Insurance Code §1202.051, which addresses guaranteed renewability, and §1301.0056, which addresses qualifying examinations for preferred and exclusive provider benefit plans. As amended by HB 3359, §1301.0056 provides that an insurer may not offer a preferred or exclusive provider benefit plan before the commissioner determines that the network meets the quality of care and network adequacy standards in Insurance Code Chapter 1301 or the insurer receives a waiver.

The proposal amends subsection (d) to require insurers to notify the commissioner of a discontinuance and amend subsection (h) to clarify requirements for uniform modifications. They also add a definition of a uniform modification in new subsection (i), clarify notice requirements by adding new subsection (j), which states that a notice provided to the commissioner under §3.3038 must be submitted as an informational filing consistent with the procedures specified in 28 TAC Chapter 3, Subchapter A, and clarify network filing requirements by adding new subsection (k).

In addition, a proposed amendment to the section title adds a comma, and another proposed amendment adds a reference to the title of Insurance Code Chapter 842 in a citation to the chapter in subsection (c)(4).

Subchapter X. Preferred and Exclusive Provider Plans

Division 1. General Requirements

28 TAC §§3.3702 - 3.2705, 3.3707 - 3.3711, and new 3.3712 and 3.3713

Section 3.3702. Definitions. The proposed amendments to §3.3702 expand the definition of "facility-based physician" in subsection (b)(8) by changing the defined term to "facility-based physician or provider," thereby including non-physician providers, and by deleting the reference to specific specialists listed in the current definition, consistent with SB 1003.

An amendment also revises subsection (b)(17) to remove the definition of "rural area," which is no longer needed with the addition of new §3.3713, and replace it with a definition for SERFF.

Amendments also add the titles of a cited Insurance Code chapter and cited Insurance Code sections in subsections (a) and (b)(1), (7), and (10).

Section 3.3703. Contracting Requirements. Proposed amendments to §3.3703 implement HB 711 and HB 1696, respectively, by adding requirements in new paragraphs (29) and (30) of subsection (a) that a contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning contract requirements, including the prohibitions on contractual anti-steering, anti-tiering, most favored nation, and

gag clauses, and Insurance Code Chapter 1451, Subchapter D, concerning access to optometrists used under managed care plan, including protections for optometrists and therapeutic optometrists in managed care plans that cover vision or medical eye care. Amendments also update a reference to "facility-based physician group" in subsection (a)(26) by adding the words "or provider" to conform with an amended definition in §3.3702.

Amendments also clarify language in the section by changing "assure" to "ensure" in subsection (a); "shall" to "must" in subsection (a)(4); "x-ray" to "X-ray" in subsection (a)(5); "therein" to "in the contract" in subsection (a)(13); "such immunizations or vaccinations" to "they" and "rules promulgated thereunder" to "implementing rules" in subsection (a)(17); "e-mail" to "email," "pursuant to" to "in accordance with," and "in accordance with" to "under" in subsection (a)(20); "methodologies" to "methods" in subsection (a)(20)(A); "pursuant to" to "in accordance with" in (a)(20)(G)(iii); and "utilized insofar as" to "employed to the extent" in subsection (b). In addition, proposed amendments add an apostrophe following the word "days" in subsection (a)(20)(D) and quotation marks around the words "batch submission" in subsection (a)(20)(D), remove parenthetical information following a citation to Insurance Code §1661.005, add the titles of cited Insurance Code sections in paragraphs (13), (14), (15), (18), (25), and (27) of subsection (a) and subsections (b) and (c), and delete an unnecessary use of the word "the" in a citation to Insurance Code §1661.005 in subsection (a)(25). Also, a citation to Insurance Code §1301.0053 is added to subsection (a)(28).

Section 3.3704. Freedom of Choice; Availability of Preferred Providers. The proposed amendments to §3.3704 remove references to §3.3725, which this proposal repeals, and add the titles of cited Insurance Code sections in subsection (a), including in paragraphs (1), (4), (5), (9), and (12). Citations in subsections (a) and (b) to specific Insurance Code sections are replaced with broader chapter and subchapter citations. The citation in subsection (a)(5) to §3.3708 is changed to reflect the proposed amendment to the section title, and the citation to 28 TAC Chapter 19, Subchapter R in subsection (a)(9) is updated to reflect the current name of that subchapter. References in subsection (a) to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Amendments in subsection (a)(7) affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and amendments in subsection (a)(9) prohibit an insurer from penalizing an insured based solely on a failure to obtain a preauthorization, as TDI views such practices as unjust under Insurance Code §1701.055(a)(2). TDI invites comments on amended subsection (a)(9) as proposed. Also, an amendment in subsection (a)(12) removes a citation to 28 TAC §3.3725 to reflect the repeal of that section.

The proposal implements Insurance Code §1458.101(i), as added by HB 711, by replacing the current subsection (e) with a new subsection (e) containing provisions that restrict the use of steering or a tiered network to encourage an insured to obtain services from a particular provider only to situations in which the insurer engages in such conduct for the primary benefit of the insured.

The proposal implements HB 3359 by amending subsection (f) to add requirements that preferred provider plans comply with new network adequacy standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Subsection (f) is also amended to delete the previous network adequacy standards and reference to local market adequacy requirements, consistent with the statutory changes in HB 3359. Subsection (g) is amended to address requirements if a material deviation from network adequacy standards occurs. Amendments to subsection (h) also implement Insurance Code §1301.005(d), as added by HB 3359, by requiring a service area to be defined in terms of one or more Texas counties, removing options to define a service area by ZIP codes or 11 Texas geographic regions, and specifying that a plan may not divide a county into multiple service areas.

In addition, amendments clarify language in the section by changing "pursuant to" to "in accordance with" in subsection (a)(1), "50 percent" to "50%" in subsection (a)(5), "is taken pursuant to the" to "are taken under" in subsection(a)(9), and "accord" to "accordance" in subsection (a)(12).

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. The proposed amendments to subsections (l) and (n) in §3.3705 implement SB 1003 by updating references to "facility-based physician" and by deleting the related listing of included specialist categories. Amendments to subsection (l) also clarify that the applicability of paragraphs (10) and (11) is consistent with Insurance Code Chapter 1451, Subchapter K.

The amendments modernize and streamline the disclosure requirements, including by shortening the name of the written description to plan disclosure in subsections (b), (c), and (f); requiring insurers to provide the plan disclosure in any plan promotion and link to the plan disclosure from the federally required summary of benefits and coverage in subsection (b); removing the requirement that a plan disclosure follow a specified order and permitting the insurer to use its policy or certificate to provide the disclosure in subsection (b); requiring availability via a website address instead of a mailing address in subsection (b)(2); requiring an explanation relating to preauthorization requirements in subsection (b)(9); conforming to the waiver disclosure requirements in HB 3359 in subsections (b)(14) and (m)(1); conforming prescription drug coverage disclosures requirements to §21.3030 in subsection (b)(4); streamlining network disclosure requirements in in subsection (b)(12); replacing service area disclosures with county disclosure to conform with HB 3359 in subsections (b)(13) and (e)(2); and conforming disclosure requirements concerning reimbursements of out-of-network claims to proposed changes in other sections, such as removing disclosure requirements for preauthorization penalties, consistent with the proposed amendment in §3.3704(a)(9).

Amendments to subsection (c) remove filing requirements for listings of preferred providers, consistent with the changes in subsection (b). A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage.

Amendments to subsection (f) replace the preferred and exclusive provider benefit plan notices to reflect balance billing protections contained in SB 1264 from 2019, to remove outdated references, and to limit the notice requirements to apply only to major medical insurance plans.

In recognition of the robust network adequacy requirements contained in HB 3359, amendments remove requirements in subsection (n) to notify TDI of provider terminations that do not impact network compliance and requirements in subsections (p)

and (q) to designate a plan network as an approved or limited hospital care network.

Amendments to subsection (o) update disclosure of payment standards for out-of-network services, consistent with the proposed changes in §3.3708. A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage. Amendments also add the titles of cited Insurance Code sections and update citations in subsection (k) to §3.3708 and §3.3725 to conform with the amendments and repeal in this proposal.

In addition, amendments clarify language in the section by changing "chapter" to "title" in subsection (a), "address" to "website address" in subsection (b)(2), and "pursuant to" to "under" in subsections (b)(14)(B) and (m)(1), Also amendments to subsections (e), (i), (j), (l), and (n)(5) make changes to simplify the text addressing information on an insurer's website by removing the words "internet" and "internet-based" and adding language using the term "website."

Section 3.3707. Waiver Due to Failure to Contract in Local Markets. The proposed amendments to §3.3707 implement HB 3359 by updating the requirements for a finding of good cause for granting a waiver from network adequacy standards, subject to statutory limits in subsection (a); requiring that a waiver request include certain information including information demonstrating a good faith effort to contract (if providers are available) and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract in subsections (b) and (c); and clarifying the commissioner's consideration of an access plan for waiver requests in subsection (c). The proposal specifies in subsections (b) and (c) that an insurer must use the process and electronic form specified in §3.3712 to file a waiver request and access plan, which will enable TDI to publish data on waivers as required by statute.

Additional amendments in subsections (b) and (d) require an insurer to use TDI's electronic form to submit the evidence supporting the waiver request and mark the document as confidential if it contains proprietary information. Required documents must be submitted in SERFF, which makes filed information publicly available, unless the insurer marks a document as confidential. Proposed amendments in subsection (d) also remove the requirement for insurers to send notices of waiver requests to physicians and providers; instead, TDI will send notices to those providers in advance of a waiver hearing. Amendments to subsection (e) clarify the process for providers to respond to a waiver request.

An amendment to subsection (h) clarifies that TDI will specify the one-year period for which the waiver will apply and will post information relating to the waiver on its website, and an amendment to subsection (g) clarifies that an insurer may request to renew a waiver in conjunction with filing the annual report as required in §3.3709.

Existing subsections (i)(1) and (2) and (j) are deleted to conform with the proposed access plan requirements of this section and filing requirements in §3.3712; references in this section to "local market access plan" are changed to remove references to local markets to conform with the changes in HB 3359.

Amendments in the text of existing subsection (k) (which is redesignated as subsection (j)) and the text of new subsection (k) update the required processes that an insurer must develop to facilitate access to covered services, provide insureds with an option to obtain care without being subject to balance billing, and ensure that insureds understand what options they have when no in-network provider is reasonably available.

New subsection (m) replaces previous access plan requirements with the requirement that insurers submit a general access plan that will apply in any unforeseen circumstance where an insured is unable to access in-network care within the network adequacy standards.

Subsection (n) is deleted, as it is outdated in view of the proposed changes relating to network waivers in this section.

Also, an amendment to subsection (a) corrects an Insurance Code citation and adds the name of the cited section. In addition, amendments clarify language in the section by changing "in accord with" to "consistent with" in subsection (a) and "pursuant to" to "in accordance with" in subsections (g)(2) and (i).

Section 3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures. Proposed amendments to §3.3708 remove existing subsections (a) and (b), which contain provisions invalidated by the TAHP Order and change the section title to replace "Basic Benefit" with "Out-of-Network" and to delete "and Related Disclosures." This text is replaced by a new subsection (a) and (b). New subsection (a) provides payment standards for certain out-of-network claims and reflect balance billing protections, consistent with SB 2476 and SB 1264. New subsection (b) provides consumer protections for network gaps.

The proposal consolidates requirements for preferred and exclusive provider benefit plans by moving some provisions from §3.3725, which is proposed for repeal, to §3.3708. Subsection (d) is amended to clarify that exclusive provider benefit plans are exempt from certain payment requirements for out-of-network services, and references to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Current subsection (e) is deleted, as it is no longer in effect. It is replaced by a new subsection (e), which implements HB 2002 by clarifying that an insurer must credit certain direct payments to nonpreferred providers towards the insured's in-network cost-sharing maximums.

Existing subsection (f) is deleted because, with the other proposed changes, application of the section should no longer be limited to exclusive provider plans. The subsection is replaced by a new subsection (f), which implements HB 1647 by clarifying that insurers must cover certain clinician-administered drugs at the in-network benefit level.

Section 3.3709. Annual Network Adequacy Report. Proposed amendments to subsections (b) and (c) revise the text of the subsections to expand the content to be included in the annual network adequacy report, including requirements for insurer identifying information and information relating to network configuration, facility access, waiver requests and access plans, enrollee demographics, complaints, and actuarial data. An amendment to subsection (c)(4) also updates a reference to "basic benefits" to clarify that the term refers to out-of-network benefits.

Amendments to subsection (d) require that annual network adequacy reports be submitted to TDI via the SERFF system using the electronic form provided by TDI and remove the option to file the report via email.

Proposed amendments to subsection (a) restructure the language of the section for clarification.

Section 3.3710. Failure to Provide an Adequate Network. Proposed amendments to subsection (a) clarify the scope of the commissioner's sanction authority. Additional amendments to subsection (a) add the titles of cited Insurance Code sections, remove references to the term "local market," and change "and/or" to "and," and amendments to subsections (a) and (b) change "pursuant to" to "under."

Section 3.3711. Geographic Regions. Proposed amendments to §3.3711 replace the ZIP code listing with a county listing, based on the regional map available at www.hhs.texas.gov, consistent with the requirement in HB 3359 that service areas may not divide a county.

Section 3.3712. Network Configuration Filings. New §3.3712 implements HB 3359 by requiring submission of network configuration information. This information is currently addressed in §3.3722. Subsections (a) and (b) clarify that network configuration filings must be submitted in SERFF and are required in connection with a waiver request under §3.3707, an annual report under §3.3709, or an application or modification under §3.3722. Subsection (c) specifies that insurers must use TDI's electronic forms when making network configuration filings and lists the information that must be included within the forms. The purposes of these electronic forms are to assist the insurer in demonstrating compliance with the network adequacy requirements contained in HB 3359 and to allow TDI to aggregate and publish information concerning networks and waivers consistent with Insurance Code §§1301.0055(a)(3), 1301.00565(g), and 1301.009. Subsection (d) clarifies that the submitted information is considered public information subject to publication by TDI.

Section 3.3713. County Classifications for Maximum Time and Distance Standards. New §3.3713 implements Insurance Code §1301.00553 as added by HB 3359, which specifies that counties are classified based on determinations made by the federal Centers for Medicare and Medicaid Services as of March 1, 2023. The new section lists each Texas county according to its classification as a large metro, metro, micro, or rural county, or a county with extreme access considerations.

Division 2. Application, Examination, and Plan Requirements

28 TAC §§3.3720, 3.3722, 3.3723, and 3.3725

Section 3.3720. Preferred and Exclusive Provider Benefit Plan Requirements. The proposed amendments to §3.3720 update the titles of administrative code sections referenced in the section; revise an incorrect citation in the section; remove a reference to §3.3725, which is repealed by this proposal; add the title to a citation to the Insurance Code; and change "pursuant to" to "under."

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The proposed amendments to §3.3722 implement HB 3359 by updating network configuration filing requirements and cross-references to conform to changes made in §§3.3038, 3.3707, 3.3708, and 3.3712, and the repeal of §3.3725. Requirements for network modifications are clarified to align with current practices.

Amendments to subsection (a) clarify that insurers must use the specified form to file an application for approval of a plan.

An amendment to subsection (b)(4) clarifies the rule text by changing passive voice to active voice.

Amendments to subsection (c) update references to service areas to refer to counties, consistent with HB 3359; update a reference to "medical peer review" to conform to statute; replace the listing of required network configuration information with a reference to proposed new §3.3712; replace citations to §3.3725, which is proposed for repeal; change "pursuant to" to "under"; and add titles to citations to the Insurance Code.

Amendments to subsection (d) clarify that the documents required for a qualifying examination must include network configuration information described in new §3.3712 that demonstrates network adequacy compliance. Amendments to subsection (d) also change "pursuant to" to "in accordance with" and "under."

Amendments to subsection (e) add a reference to new §3.3712; require that for nonrenewals resulting from a service area reduction, insurers must comply with §3.3038, as amended in this proposal; and remove the requirement that insurers must comply with §3.3724 to receive approval of a service area expansion or reduction application for certain exclusive provider benefit plans.

Section 3.3723. Examinations. Proposed amendments to §3.3723 change "pursuant to" to "under" and "in accordance with" and "in accord with" to "in accordance with"; add the titles of cited Insurance Code, Administrative Code, and Occupations Code provisions; and add a citation to new §3.3712.

Section 3.3725. Payment of Certain Out-of-Network Claims. The proposal repeals §3.3725 to conform with the proposed amendments to §3.3708 and to remove sections invalidated by the TAHP Order.

In addition, the proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include adding headings to cited statutes and rules; removing references to §3.3725, which is repealed by this proposal; updating cross-references to other rules; updating terminology, including references to access plans, out-of-network level of coverage, and service areas; nonsubstantive text edits, including removing extraneous words such as "the" from statutory citations; and grammatical, punctuational, and format changes to reflect TDI's current drafting style and plain language preferences.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the sections as proposed are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the proposed sections, other than that imposed by statute. Ms. Bowden made this determination because the sections as proposed do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed sections.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the sections as proposed are in effect, Ms. Bowden expects that enforcing and administering them will have the public benefits of ensuring that TDI's rules properly implement House Bills 711, 1647, 1696, 2002, and 3359, and Senate Bills 1003, 2476, and 1264, and the TAHP Order. The proposed amendments to §3.3704 will have the public benefit of ensuring that health plan requirements are fair to insureds and that

the plan provides benefits consistent with how the plan is advertised. The proposed amendments to §3.3705 will have the public benefit of making it easier for insureds to find information about the policy terms and conditions, network breadth, and network waivers. The proposed amendments to §3.3708 will have the public benefit of ensuring that insureds are protected in any case where they obtain out-of-network care because they are unable to reasonably access in-network care. The proposed amendments to §§3.3707, 3.3709, and 3.3711 and new §3.3712 and §3.3713 will benefit the public by ensuring that TDI collects the information necessary to thoroughly evaluate network adequacy and requests for waivers, consistent with new statutory requirements. This proposal will ensure that insureds who purchase preferred and exclusive provider benefit plans are able to access medically necessary covered services from preferred providers or through an access plan facilitated by the insurer, without being subject to extra costs.

Ms. Bowden expects that the sections as proposed will impose an economic cost on persons required to comply with them. However, some of those costs may be offset by cost savings created by amendments to existing rules.

Costs

The proposed amendments to §3.3707 and §3.3709 and new §3.3712 require insurers to make network filings, including waiver requests, using SERFF. Since the use of SERFF is not currently required, the proposed amendments could have a cost impact on any insurer that currently submits network filings outside of SERFF. In 2023, SERFF charges a fee of $17.61 for each filing. TDI is not able to predict how many network filings will be required when the proposed new and amended sections become effective, but past experience may be helpful in estimating the potential cost impact. In the past five years, TDI has not received any network filings for a licensed insurer outside of SERFF. Therefore, Ms. Bowden estimates that this change in practice will not have a cost impact on insurers subject to the proposal. Insurers voluntarily use SERFF because it provides a cost-effective option for insurers to transmit filings, store information, communicate with TDI staff, make information publicly available, and designate any information that is proprietary or confidential. Continued acceptance of filings through email would be less efficient and less technically secure for both TDI and insurers. The use of SERFF filings helps TDI comply with Government Code Chapter 552 by facilitating the appropriate release of information while including the necessary technical safeguards to protect confidential information.

The proposed amendments to §3.3707 and §3.3709 and new §3.3712 require insurers to use electronic forms published on TDI's website to provide the information specified in the proposed rules. Currently, TDI publishes example forms for network filings, which insurers can use if they choose. TDI forms help insurers make filings that meet all requirements. In implementing HB 3359, the required use of TDI's provider listings form is necessary to enable TDI to use software that can validate an insurer's compliance with time and distance standards specified in Insurance Code §1301.00553. The required use of TDI's network compliance and waiver request form to document network compliance and summarize network waiver requests and associated access plans is necessary to enable TDI to confirm compliance with network adequacy standards, compile information on provider networks and waivers, and publish that information in a comparable format as required in Insurance Code §1301.0055 and §1301.009. The required use of TDI's attempt to contract form to document good faith efforts to contract is needed for TDI to consider waiver requests and evaluate whether good cause for a waiver is shown. The required use of TDI's annual network adequacy report form to collect annual report information is needed to help TDI evaluate the impact that any network gaps and waivers have on insureds and providers. Insurers may face administrative costs associated with updating internal data systems to submit network information using TDI's electronic forms. Some of these costs will be offset by savings. For example, TDI proposes to remove the requirement for insurers to submit extensive maps to illustrate distance standards compliance. The proposed submission requirements may also be less costly to the extent that they align more closely with federal requirements for insurers that offer qualified health plans in the individual market. While it is not feasible to determine the actual cost of any employees needed, Ms. Bowden estimates that making the required filings to comply with HB 3359 using TDI's new required electronic forms may necessitate:

- between 20 and 80 hours for a computer programmer on a one-time basis; and

- between 10 and 40 hours for a compliance officer to populate the forms each time a network filing is made.

Some of these costs are attributable to statute and would be incurred even if TDI did not require the use of specific forms. Staff costs may vary depending on the skill level required and the geographic location where work is done. According to the Texas Wages and Employment Projections database, which is developed and maintained by the Texas Workforce Commission and located at www.texaswages.com/WDAWages, the average hourly wage in Texas is $44.98 for a computer programmer and $35.31 for a compliance officer.

The proposed amendment to §3.3704(a)(9) prohibits insurers from penalizing an insured for failure to obtain preauthorization before accessing medically necessary care. This does not impact contractual requirements with preferred providers related to preauthorization requirements and does prevent an insurer from retrospectively reviewing a claim for a service that was not preauthorized and denying a claim if it fails to meet medical necessity standards. To the extent that an insurer is currently imposing and collecting such penalties, this provision could decrease the portion of claims paid by insureds and increase the portion of claims paid by the insurer. TDI does not have data available that allows it to estimate how often such penalties are imposed and invites comment on this issue.

The proposed amendments to §3.3705(b) modify when and how insurers are required to provide the written description of policy terms and conditions (plan disclosure) and simplify the information that must be included. The proposed amendments allow insurers to use the federally required summary of benefits and coverage (SBC) as a method to deliver access to the disclosure. They also remove the requirement that the plan disclosure be listed in a particular order and allow insurers to use its policy or certificate to satisfy the disclosure requirements. Collectively, this provides significant flexibility for insurers and reduces the number of separate documents the insurer must produce that reflect plan-specific information. Ms. Bowden estimates that the flexibility added in the proposed amendments will save insurers between eight and 24 hours of time for a compliance officer (earning an average wage of $35.41 per hour in Texas, as cited previously) for each plan offered.

The proposed amendments to §3.3707(d) remove the requirement for insurers to send a notice to each provider they attempt to contract with, concurrent with filing a waiver request to TDI. Ms. Bowden estimates that removing this requirement will save insurers between eight and 16 hours of time that otherwise would be needed to send those notices for each network for which a waiver request is filed. According to the Texas Wages and Employment Projections database, an Office and Administrative Support worker in Texas earns an average hourly wage of $20.59.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the sections as proposed will not have an adverse economic impact on rural communities, but they may have an adverse economic effect on small or micro businesses. Rural communities will not be adversely impacted because the rule applies only to insurers. The cost analysis in the Public Benefit and Cost Note section also applies to these small or micro businesses. TDI estimates that the sections as proposed may affect between zero and three small or micro businesses. This proposal's primary objective is to ensure that preferred and exclusive provider benefit plans contract with a sufficient number and type of providers to provide sufficient access to all types of covered health care services to all insureds across the plans' service areas. The proposal also aims to ensure that consumers are adequately informed about their rights and protected from balance billing that may occur if they are unable to reasonably access covered health care services within the network adequacy standards. TDI considered the following alternatives to minimize any adverse impact on small or micro businesses while accomplishing the proposal's objectives:

(1) exempting small or micro businesses from the sections as proposed;

(2) providing additional time for small or micro businesses to comply; and

(3) exempting small or micro businesses from the proposed requirement to submit network filings in SERFF using TDI's electronic forms.

After considering Option 1, TDI declined to exempt small or micro businesses from the sections as proposed because TDI does not have authority to exempt these businesses from compliance with the new laws, and the rules as proposed work together to implement the new laws. Without the guidance and clarification provided by the proposal, small or micro businesses would have more difficulty complying with the new statutory requirements.

In regard to Option 2, TDI determined that extending the compliance deadline for small or micro businesses was not supported by statute. Providing additional time for some businesses and not others would create an unlevel playing field and provide inequitable protections for consumers depending on whether they enrolled in a plan offered by a small or micro business.

In considering Option 3, TDI determined that exempting small or micro businesses from requirements to submit network filings in SERFF and to use TDI forms would create a significant burden on agency staff to review information submitted in a nonstandard format. Without the standardized format in the TDI forms, TDI would be unable to publish uniform information on waivers or would need to do significant manual data entry or manual compliance analysis. In addition, exempting a small or micro business from the requirements to submit network filings via SERFF would require agency staff to maintain a separate process for handling such filings. To maintain agency records, staff would have to manually upload multiple types of filings, and all communications related to those filings, into SERFF throughout the year. These manual processes would strain agency resources and create opportunities for errors.

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 the proposed rule is necessary to implement legislation. The proposed rule implements SB 1264 from the 86th legislative session and the following bills from the 88th legislative session: House Bills 711, 1647, 1696, 2002, and 3359, and Senate Bills 1003 and 2476. The proposed rule also includes amendments to reduce the burden or responsibilities imposed on regulated persons by the rule or decrease their costs of compliance. TDI has solicited input from regulated entities and the Centers for Medicare and Medicaid Services to determine cost-effective methods of compliance that align with current state and federal regulatory standards and compliance practices, and TDI has considered such input when drafting this proposal.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the sections as proposed are in effect, the proposed rule:

- 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 create new regulations;

- will expand, limit, and repeal existing regulations;

- will increase 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 a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on January 10, 2024. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2842 at 2:30 p.m., central time, on January 9, 2024, in Room 2.029 of the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701.

SUBCHAPTER S. MINIMUM STANDARDS AND BENEFITS AND READABILITY FOR

INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES

28 TAC §3.3038

STATUTORY AUTHORITY. TDI proposes amendments to §3.3038 under Insurance Code §§1202.051, 1301.0056, and 36.001.

Insurance Code §1202.051 requires the commissioner to adopt rules necessary to implement the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

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. The proposed amendments to §3.3038 implement Insurance Code Chapters 1202 and 1301.

§3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions.

(a) Except as provided by [~~subsection (c) of~~] this section, all individual hospital, medical, or surgical coverage (as defined in §3.3002(b)(12) of this title (relating to Definitions)) must be renewed or continued in force at the option of the insured.

(b) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of individual hospital, medical, or surgical coverage; however, such coverage sold to an insured before the insured attains Medicare eligibility may contain a clause that excludes payments for benefits under the policy to the extent that Medicare pays for such benefits.

(c) Individual hospital, medical, or surgical coverage may only be discontinued or nonrenewed based on one or more of the following circumstances:

(1) the policyholder has failed to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(2) the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy;

(3) the insurer is ceasing to offer individual hospital, medical, or surgical coverage under the particular type of policy, or is ceasing to offer any form of individual hospital, medical, or surgical coverage in this state or in the insurer's service area, in accordance with subsections (d) and (e) of this section;

(4) in regard [~~regards~~] only to coverage offered by an issuer under Insurance Code Chapter 842, concerning Group Hospital Service Corporations, or Chapter 1301, concerning Preferred Provider Benefit Plans, the insured no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health-status-related factor of covered individuals.

(d) An insurer may elect to discontinue offering a particular type of individual hospital, medical, or surgical coverage plan in the individual market only if the insurer:

(1) provides written notice to the commissioner and each covered individual of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage;

(2) offers to each covered individual on a guaranteed issue basis the option to purchase any other individual hospital, medical, or surgical insurance coverage offered by the insurer at the time of the discontinuation; and

(3) acts uniformly without regard to any health-status related factors of a covered individual or dependents of a covered individual who may become eligible for the coverage.

(e) An insurer may elect to refuse to renew all individual hospital, medical, or surgical coverage plans delivered or issued for delivery by the insurer in this state or in the insurer's service area, only if the insurer:

(1) notifies the commissioner of the election not later than the 180th day before the date coverage under the first individual hospital, medical, or surgical health benefit plan terminates;

(2) notifies each affected covered individual not later than the 180th day before the date on which coverage terminates for that individual; and

(3) acts uniformly without regard to any health-status related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) An insurer that elects not to renew all individual hospital, medical, or surgical coverage in Texas or in the insurer's service area in accordance with subsection (e) of this section may not issue any such coverage in Texas or in the insurer's service area during the five-year period beginning on the date of discontinuation of the last such coverage not renewed.

(g) Nothing in this section prohibits or restricts an insurer's ability to make changes in premium rates by classes in accordance with applicable laws and regulations.

(h) Nothing in this section may be interpreted as prohibiting an insurer from making policy modifications mandated by state law, or, acting consistently with §3.3040(b) of this title (relating to Prohibited Policy Provisions), from honoring requests from a policyholder for modifications to an individual policy or offering policy modifications uniformly to all insureds under a particular policy form, if:[.]

(1) the modification meets the definition of a uniform modification under subsection (i) of this section; and

(2) the notice describes the uniform modifications and includes any rate change notice required under Insurance Code §1201.109, concerning Notice of Rate Increase for Major Medical Expense Insurance Policy.

(i) For the purposes of this section, a "uniform modification" is a change to coverage that is made at the time of coverage renewal, applies uniformly for all insureds covered under the policy form, and complies with the requirements of 45 CFR §147.106(e) and (f), concerning Guaranteed Renewability of Coverage.

(j) A notice that is required to be provided to the commissioner under this section must be submitted as an informational filing consistent with the procedures specified in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(k) If a nonrenewal addressed under this section occurs in connection with a change to the insurer's service area, the insurer must make network configuration filings consistent with requirements

in Chapter 3, Subchapter X, of this title (relating to Preferred and Exclusive Provider Plans).

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

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304350
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 676-6555

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SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS

28 TAC §§3.3702 - 3.3705, 3.3707 - 3.3713

STATUTORY AUTHORITY. TDI proposes amendments to §§3.3702 - 3.3705 and 3.3707 - 3.3711 and new §3.3712 and §3.3713 under Insurance Code §§541.401, 1301.0055, 1301.0056, 1301.007, 1369.057, 1458.004, 1701.060, and 36.001.

Insurance Code §541.401 authorizes the commissioner to adopt reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards that include requirements set out in the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

Insurance Code §1369.057 authorizes the commissioner to adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

Insurance Code §1701.060 authorizes the commissioner to adopt reasonable rules necessary to implement the purposes of Chapter 1701.

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. The proposed amendments to §§3.3702 - 3.3705, 3.3707 - 3.3711, and new §3.3712 and §3.3713 implement Insurance Code Chapters 1301, 1369, 1451, and 1458.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Adverse determination--As defined in Insurance Code §4201.002(1), concerning Definitions.

(2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(4) Complainant--As defined in §21.2502 of this title (relating to Definitions).

(5) Complaint--As defined in §21.2502 of this title.

(6) Contract holder--An individual who holds an individual health insurance policy, or an organization that holds a group health insurance policy.

(7) Facility--As defined in Health and Safety Code §324.001(7), concerning Definitions.

(8) Facility-based physician or provider--A physician or health care provider [~~radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon~~]:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(9) Health care provider or provider--As defined in Insurance Code §1301.001(1-a).

(10) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14), concerning Definitions.

(11) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

(12) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(13) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(14) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

(15) Pediatric practitioner--A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

(16) Provider network--The collective group of physicians and health care providers available to an insured under a preferred or

exclusive provider benefit plan and directly or indirectly contracted with the insurer of a preferred or exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(17) SERFF--The National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filings. [~~Rural area--~~]

[~~(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;~~]

[~~(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or~~]

[~~(C) any other area designated as rural under rules adopted by the , notwithstanding subparagraphs (A) and (B) of this paragraph.~~]

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to ensure [~~assure~~] that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider must [~~shall~~] not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, X-ray [~~x-ray~~], or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process, including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 - 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in [~~the~~] Insurance Code §1301.067, concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited, about any of the matters set forth in the contract [~~therein~~].

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with [~~the~~] Insurance Code §1301.058, concerning Economic Profiling.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of [~~the~~] Insurance Code §1301.059(b), concerning Quality Assessment.

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if they [~~such immunizations or vaccinations~~] are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, and implementing rules [~~promulgated thereunder~~].

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in [~~the~~] Insurance Code §1301.160(b), concerning Notification of Termination of Participation of Preferred Provider.

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including email [~~e-mail~~], computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided in accordance with [~~pursuant to~~] this paragraph are required to be made under [~~in accordance with~~] subparagraph (D) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methods [~~methodologies~~] that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided under [~~pursuant to~~] this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days' [~~days~~] written notice to the preferred provider identifying with specificity the amendment, revision, or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon re-

ceipt of a request, the insurer is required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided in accordance with [~~pursuant to~~] this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

(I) The provisions of this paragraph may not be waived, voided, or nullified by contract.

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" [~~batch submission~~] is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to whom the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of [~~the~~] Insurance Code §1661.005, concerning Refund of Overpayment. [~~(relating to refunds of overpayments from enrollees).~~]

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician or provider group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care and §1301.155(a), concerning Emergency Care, that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.0053 and §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contract Requirements.

(30) A contract between an insurer and a preferred provider must comply with Insurance Code Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, and the provisions of that subchapter will be employed to the extent [~~utilized insofar as~~] practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code Chapter 1701, concerning Policy Forms [~~§§1701.002 - 1701.005; 1701.051 - 1701.060; 1701.101 - 1701.103; and 1701.151~~], or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, or Chapter 544, Subchapter B, concerning Other General Prohibitions Against Discrimination by Insurers [~~§§544.051 - 544.054~~], or to violate [~~§§1451.001, 1451.053, 1451.054, or 1451.101 - 1451.127 of the~~] Insurance Code Chapter 1451, Subchapter A, concerning General Provisions; Subchapter B, concerning Designation of Practitioners Under Accident and Health Insurance Policy; or Subchapter C, concerning Selection of Practitioners, provided that:

(1) in accordance with [~~pursuant to~~] Insurance Code §§1251.005, concerning Payment of Benefits; 1251.006, concerning Policy May Not Specify Service Provider; 1301.003, concerning Preferred Provider Benefit Plans and Exclusive Provider Benefit Plans Permitted, 1301.006, concerning Availability of and Accessibility to Health Care Services; 1301.051, concerning Designation as Preferred Provider; 1301.053, concerning Appeal Relating to Designation as Preferred Provider; 1301.054, concerning Notice to Practitioners of Preferred Provider Benefit Plan; 1301.055, concerning Complaint Resolution; 1301.057 - 1301.062, concerning Termination of Participation; Expedited Review Process, Economic Profiling, Quality Assessment, Compensation on Discounted Fee Basis, Preferred Provider Networks, and Preferred Provider Contracts Between Insurers and Podiatrists; 1301.064, concerning Contract Provisions Relating to Payment of Claims; 1301.065, concerning Shifting of Insurer's Tort Liability Prohibited; 1301.151, concerning Insured's Right to Treatment; 1301.156, concerning Payment of Claims to Insured; and 1301.201, concerning Contracts with and Reimbursement for Nurse First Assistants, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in [~~the~~] Insurance Code §§1301.152 - 1301.154, concerning Continuing Care in General, Continuity of Care, and Obligation for Continuity of Care of Insurer, respectively;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care; and §3.3708 of this title (relating to Payment of Certain Out-of-Network [~~Basic Benefit~~] Claims and Related Disclosures) [~~and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims)~~];

(6) the out-of-network (basic) [~~basic~~] level of coverage, excluding a reasonable difference in deductibles, is not more than 50% [~~50 percent~~] less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer, including by requiring an insured to select a primary care physician or provider or obtain a referral before seeking care;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the out-of-network [~~basic~~] level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan [~~is~~] are taken under [~~pursuant to the~~] Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy [~~Review Agents~~]) and the insurer does not penalize an insured solely on the basis of a failure to obtain a preauthorization;

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and out-of-network [~~basic~~] level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accordance [~~accord~~] with Insurance Code §1301.005, concerning Availability of Preferred Providers, and §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services, and §3.3708 [~~and §3.3725~~] of this title, as applicable.

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code Chapter 1701 [~~§§1701.002 - 1701.005, 1701.051 - 1701.060, 1701.101 - 1701.103, and 1701.151~~]; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or Chapter 544, Subchapter B; [~~§§544.051 - 544.054,~~] or to violate Insurance Code Chapter 1451, Subchapter C [~~§§1451.101 - 1451.127~~], provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) - (10) and (12) of this section; and

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section only if the insurer engages in that conduct for the primary benefit of the insured or policyholder, consistent with Insurance Code §1458.101(i), concerning Contract Requirements. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific providers;

(2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred providers to tiers within the network that are associated with different levels of cost sharing.

[(e) Access to certain institutional providers. In addition to the requirements for availability of preferred providers set forth in Insurance Code §1301.005, any insurer offering a preferred provider benefit plan must make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under the plan freedom of choice in the selection of institutional providers at which they will receive care, unless the mix is not feasible due to geographic, economic, or other operational factors. An insurer must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.]

(f) Network requirements.

(1) Each preferred provider benefit plan must include a health care service delivery network that complies with:

(A) Insurance Code §1301.005;

(B) Insurance Code §1301.0055, concerning Network Adequacy Standards;

(C) Insurance Code §1301.00553, concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, which applies maximum travel time in minutes and maximum distance in miles for a county based on the county's classification as specified in §3.3713 of this title (relating to County Classifications for Maximum Time and Distance Standards);

(D) Insurance Code §1301.00554, concerning Other Maximum Distance Standard Requirements; Commissioner Authority;

(E) Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards, effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025; and

(F) Insurance Code §1301.006 [and the local market adequacy requirements described in this section].

(2) An adequate network must,[:] for each insured residing in the service area, ensure that all insureds can access at least one preferred provider and 90% of insureds can access a choice of at least two preferred providers within the time and distance standards specified in Insurance Code §1301.00553 and §1301.00554.

(3) To provide a sufficient number of the specified types of preferred providers with the specialty types listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility.

[(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:]

[(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and]

[(B) projected utilization of covered health care services;]

[(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;]

[(3) include sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;]

[(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;]

[(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;]

[(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;]

[(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;]

[(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:]

[(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and]

[(B) 75 miles for specialty care and specialty hospitals;]

[(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;]

[(10) ensure that routine care is available and accessible from preferred providers:]

[(A) within three weeks for medical conditions; and]

[(B) within two weeks for behavioral health conditions;]

[(11) ensure that preventive health services are available and accessible from preferred providers:]

[(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and]

[(B) within three months for an adult.]

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. Consistent with Insurance Code §1301.0055, an insurer must report any material deviation from the network adequacy standards to the department within 30 days of the date the material deviation occurred. Unless there are no uncontracted licensed physicians

or providers within the affected area, or the insurer requests a waiver, the insurer must take corrective action to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but may not divide a county. Any [~~any~~] service areas that are smaller than statewide must be defined in terms of one or more Texas counties. [~~one of the following:~~]

[~~(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this title (relating to Geographic Regions);~~]

[~~(2) one or more Texas counties; or~~]

[~~(3) the first three digits of ZIP Codes in Texas.~~]

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this title [~~chapter~~] (relating to Plain Language Requirements).

(b) Plan disclosure. [~~Disclosure of terms and conditions of the policy.~~] The insurer is required, in any promotion, advertisement, or enrollment opportunity, [~~on request,~~] to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy (plan disclosure) that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its policy, certificate, or handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection, including the level of disclosure required. An insurer that is required by federal law to provide a summary of benefits and coverage (SBC) must include in the SBC a link to the plan disclosure required in this subsection. The written plan disclosure [~~description~~] must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items [~~in the following order~~]:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll-free number, unless exempted by statute or rule, and website address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and, if prescription drug coverage is included, the name of the formulary used by the plan, a link to the online formulary, and an explanation regarding how a nonelectronic copy may be obtained free of charge; [~~both generic and name brand;~~]

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance, or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and an explanation that unless a provider obtains preauthorization, a claim could be denied if a service is not medically necessary or appropriate, or if a service is experimental or investigational; [~~any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;~~]

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) the name of the provider network used by the plan, a link to the online provider listing, and information on [~~a current list of preferred providers and complete descriptions of the provider networks, including the name, street address, location, telephone number, and specialty, if any, of each physician and health care provider, and a disclosure of whether the preferred provider is accepting new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding~~] how a nonelectronic copy may be obtained free of charge;

(13) the counties included in the plan's service area [~~area(s)~~]; and

(14) information that is updated at least annually regarding the following network demographics for each county [~~service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis~~]:

(A) the number of insureds in the service area or region; and

(B) for each provider area of practice and applicable network adequacy standard, [~~including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery,~~] the number of preferred providers, as well as an indication of whether an active waiver and access plan [~~pursuant to~~] under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) [~~§3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan)~~] applies to the services furnished by that class of provider in the county [~~service area or region~~] and how such access plan may be obtained or viewed, if applicable. [~~; and~~]

[~~(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.~~]

[(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:]

[(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;]

[(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and]

[(C) the information must identify how to obtain or view the local market access plan.]

(c) Filing required. A copy of the plan disclosure [written description] required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. [Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Submit provider listings as specified on the department's website.]

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of out-of-network [basic] benefits, except in the case of an exclusive provider benefit plan.

(e) Website [Internet website] disclosures. Insurers that maintain a [an Internet] website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide on their website a:

(1) [an internet-based] provider listing for use by current and prospective insureds and group contract holders;

(2) [an internet-based] listing of the [state regions,] counties [, or three-digit ZIP Code areas] within the insurer's service area [area(s)], indicating as appropriate for each [region,] county [or ZIP Code area, as applicable,] that the insurer has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter; and

(3) [an internet-based] listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that provides major medical insurance and is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan that provides major medical insurance, in all policies, certificates, plan disclosures [of policy terms and conditions] provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.
[Figure: 28 TAC §3.3705(f)(1)]
Figure: 28 TAC §3.3705(f)(1)

(2) Exclusive provider benefit plan notice.
[Figure 28 TAC §3.3705(f)(2)]
Figure 28 TAC §3.3705(f)(2)

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates its listing of preferred providers on its [Internet] website at least once a month, as required by Insurance Code §1451.505, concerning Physician and Health Care Provider Directory on Internet Website. The insurer must ensure that it updates all other electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no [Internet-based] preferred provider website listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(a)(5) [§3.3708(b) - (d)] of this title (relating to Payment of Certain Out-of-Network [Basic Benefit] Claims [and Related Disclosures]), and the insurer must take responsibility for any balance bill amount the nonpreferred provider may charge in excess of the insurer's payment [and §3.3725(d) - (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable,] if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any website [~~Internet-based~~] postings by the insurer to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (11) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good-faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or provider or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or provider or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists [~~, and assistant surgeons~~].

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians or providers able to provide services at preferred provider facilities, if applicable.

(7) The provider information must be provided in at least 10-point type [~~font~~].

(8) The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The provider information must be dated.

(10) Consistent with Insurance Code Chapter 1451, Subchapter K, concerning Health Care Provider Directories, for [~~For~~] each health care provider that is a facility included in the listing, the insurer must:

(A) create separate headings under the facility name for radiologists, anesthesiologists, anesthesiologist assistants, nurse anesthetists, nurse midwives, pathologists, emergency department physicians, neonatologists, physical therapists, occupational therapists, speech-language pathologists, and surgical assistants, except that a physician or health care provider who is employed by the facility is not required to be listed [~~assistant surgeons~~];

(B) under each heading described by subparagraph (A) of this paragraph, list each preferred facility-based physician or provider practicing in the specialty corresponding with that heading;

(C) for the facility and each facility-based physician or provider described by subparagraph (B) of this paragraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician or provider, or facility-based physician or provider group;

(D) for each facility-based physician or provider described by subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician or provider group in which the facility-based physician or provider practices; and

(E) include the facility in a listing of all facilities and indicate:

(i) the name of the facility;

(ii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(iii) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.

(11) Consistent with Insurance Code Chapter 1451, Subchapter K, the [~~The~~] listing must list each facility-based physician or provider individually and, if a physician or provider belongs to a physician or provider group, also as part of the physician or provider group.

(m) Annual policyholder notice concerning use of an [~~a local market~~] access plan. An insurer operating a preferred provider benefit plan that relies on an [~~a local market~~] access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of information on network waivers and access plans [~~regions, counties, or ZIP codes~~] made available under [~~pursuant to~~] subsection (e)(2) of this section;

(2) information on how to obtain or view any [~~local market~~] access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians or providers at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician or provider group that comprises 75% or more of the preferred providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician or provider group that comprises 75% or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred providers of the same specialty as the physician or provider group that terminates a contract as specified in paragraph (1) of this subsection are made available to insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer determines [~~provides to the department, by email to mcqa@tdi.texas.gov, a certification of the insurer's determination~~] that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers)[~~,~~] as those standards apply to the applicable provider specialty.

(3) An insurer must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.[~~; or~~]

[~~(C) the date on which the insurer provides to the department, by email to mcqa@tdi.texas.gov, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer's determination that the termination of provider contract does not cause noncompliance with adequacy standards.~~]

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its website [~~Internet-based~~] preferred provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an insurer receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) An insurer must disclose how the plan will cover out-of-network services received when medically necessary covered services are not reasonably available through a preferred provider, consistent with §3.3708 of this title and how an enrollee can obtain assistance with accessing care in these circumstances, consistent with §3.3707(k) of this title.

[~~(2) Except in an exclusive provider benefit plan, if an insurer reimburses nonpreferred providers based directly or indirectly on data regarding usual, customary, or reasonable charges by providers, the insurer must disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.~~]

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer, unless balance billing protections apply, as specified in §3.3708(a)(1) - (4) of this title;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

[~~(p) Plan designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this title without reliance on an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":~~]

[~~(1) on the insurer's outline of coverage; and~~]

[~~(2) on the cover page of any provider listing describing the network.~~]

[~~(q) Loss of status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:~~]

[~~(1) notify the department in writing concerning such change in status as specified on the department's website;~~]

[~~(2) cease marketing the plan as an AHCN; and~~]

[~~(3) inform all insureds of such change of status at the time of renewal.~~]

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) Consistent [~~In accord~~] with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards [~~§1301.0055(3)~~], where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a county [~~portion of the state~~] that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the [~~The~~] commissioner may grant the waiver if the requestor shows [~~there is~~] good cause based on one or more of the criteria specified in this subsection and subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver. The commissioner may find good cause to grant the waiver if the insurer demonstrates that [~~providers or physicians necessary for an adequate local market network~~]:

(1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area; [~~are not available to contract;~~] or

(2) physicians or health care providers necessary for an adequate network have refused to contract with the insurer on any terms or on terms that are reasonable.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department. For each waiver requested with respect to a type of physician or provider in a given county, the insurer must provide [~~At a minimum, each waiver an insurer requests must include~~] either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include, within the attempt to contract form:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type, and including the physician or provider's address and county; national provider identifier, contact name, email, and phone number; and for facility-based physicians or providers, the group name and associated facility;

(B) a description of how and when the insurer last contacted each provider or physician that demonstrates that the insurer made a good faith effort to contract, including:

(i) in the case of a waiver that is being requested more than two consecutive times for the same network adequacy standard in the same county, evidence that the insurer made multiple good faith attempts during each of the prior consecutive waiver periods;

(ii) in the case of a waiver that is being requested more than four times within a 21-year period for the same network adequacy standard in the same county, evidence that the insurer has been unable to remedy the issue through good faith efforts;

(C) for each provider or physician contacted, a description of the best offer of reimbursement rates made by the issuer, computed by describing the rate for each service for which a contract was offered as a percent of:

(i) the Medicare rates for those services that applied at the time the contract was attempted and providing an average of the rates as a percent of the Medicare rate (e.g., rates offered were 135% of the Medicare rate); and

(ii) the insurer's average contracted rate with preferred providers in a similar geographic area for those services and providing an average of the rates as a percent of the average contracted rate (e.g., rates offered were 108% of the average contracted rate);

(D) [~~(C)~~] a description of any reason each provider or physician gave for refusing to contract with the insurer, including information on any exclusivity arrangement or other external factors that affect the ability of the parties to contract;

[~~(D) an estimate of total claims cost savings per year the insurer anticipates will result from using a local market access plan instead of contracting with providers located within the service area, and its impact on premium; and~~]

(E) a description of all steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary;[~~.~~]

(F) a description of the source or sources the insurer uses to identify physicians and providers that are available in the service area, and how often the insurer monitors these sources for new physicians and providers entering the service area; and

(G) a description of the insurer's policies and procedures for reaching out to available physicians and providers, including how many attempts the insurer makes and if different policies and procedures apply for different specialty types.

(2) If an insufficient number of [~~no~~] providers or physicians is [~~are~~] available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

(c) At the same time an insurer files a request for waiver or a request to renew a waiver, it must file an [~~a local market~~] access plan, [~~as specified in subsection (i) of this section,~~] to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request, subject to Insurance Code §1301.00566, concerning Effect of Network Adequacy Standards Waiver on Balance Billing Prohibitions. The insurer must:

(1) develop access plan procedures consistent with subsection (j) of this section; and

(2) file the access plan as required in §3.3712(c)(2)(E)(iii) of this title.

(d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code 1301.00565(g), certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When

scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any provider or physician named in the waiver request. [An insurer seeking a waiver under subsection (a) of this section must electronically file the request with the department at the Office of the Chief Clerk through the following email address: chiefclerk@tdi.texas.gov. The insurer must also submit a copy of the request to any provider or physician named in the waiver request at the same time the insurer files the request with the department, but is permitted to redact information from the copy where provision of the information to the provider or physician would violate state or federal law. The insurer may use any reasonable means to submit the copy of the request to the provider or physician. The insurer must maintain proof of the submission and include a copy of the redacted version with the waiver request submitted to the department.]

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by sending an email to networkwaivers@tdi.texas.gov within 15 days after receiving notice from the department. [filing the response within 30 days after the insurer files the request with the department.] The response, if filed, must indicate whether the provider or physician consents to being identified at a hearing related to the waiver request and may include evidence that is pertinent to the waiver request for the commissioner's consideration. [be filed at the same address specified in subsection (d) of this section for filing the request for waiver.]

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, consistent with Insurance Code §1301.0055(a)(3). [including:]

[(1) the name of the preferred provider benefit plan for which the request is granted;]

[(2) the insurer offering the plan; and]

[(3) the affected service area.]

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section and submitted at the time the insurer files its annual report under §3.3709 of this title (relating to Annual Network Adequacy Report). [at least 30 days prior to the anniversary of the department's grant of waiver.]

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must develop and file any applicable [local market] access plan the insurer uses in accordance with [pursuant to] the waiver, in the manner specified by subsection (c) [(i)(2)] of this section.

[(3) A waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal.]

(h) When granting a waiver, the department will specify the one-year period for which the waiver will apply. A waiver will expire at the end of the period specified by the department unless the insurer requests [one year after the date the department granted it if an insurer fails to timely request] a renewal under subsection (g) of this section and [or if] the department approves [denies] the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific county [service area], the insurer must establish an [a local market] access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver in accordance with [pursuant to] subsection (a) of this section requesting that the department approve the continued use of the [local market] access plan.

[(1) The local market access plan must contain all the information specified in subsection (j) of this section.]

[(2) The insurer must file the local market access plan with the department by email at: mcqa@tdi.texas.gov or through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing.]

[(j) A local market access plan required under subsection (i) of this section must specify for each service area that does not meet the network adequacy requirements:]

[(1) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this title, including a specification of the class of provider that is not sufficiently available;]

[(2) a map, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, or providers are not available;]

[(3) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this title;]

[(4) procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and]

[(5) procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims).]

(j) [(k)] An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which an [a local market] access plan is submitted, as required by subsections (c), (i), or (m) of this section. These procedures must be made available to the department upon request. When a preferred provider is not available within the network adequacy standards under §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) to provide a medically necessary covered service, the insurer must use a documented procedure to:

[(1) The insurer must utilize a documented procedure to:]

(1) [(A)] identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(2) upon request by an insured or an individual acting on behalf of an insured, and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient but in no event to exceed five business days, approve a network gap exception and facilitate access to care by recommending at least one physician or provider that:

(A) has expertise in the necessary specialty;

(B) is reasonably available considering the medical condition and location of the insured; and

(C) the insured may choose to use without being liable for any amount charged by the physician or provider that exceeds the

insured's cost-sharing responsibilities under the preferred provider benefit level;

(3) [~~(B)~~] furnish to insureds, prior to the services being rendered, an explanation of their rights, consistent with §3.3708(b)(1)(B) of this title (relating to Payment of Certain Out-of-Network Claims); [~~estimate of the amount the insurer will pay the physician or provider; and~~]

(4) [~~(C)~~] except when a provider is prohibited from balance billing, as specified in §3.3708(a)(1) - (4) of this title [~~in the case of an exclusive provider benefit plan~~], notify insureds that they may be liable for any amounts charged by the physician or provider that are more than the insurer's reimbursement rate, unless the insured uses a provider recommended by the insurer [~~not paid in full by the insurer~~].

[~~(2) The insurer must utilize a documented procedure to:~~]

(5) [~~(A)~~] identify claims filed by nonpreferred providers in instances in which no preferred provider was [~~reasonably~~] available to the insured; and

(6) [~~(B)~~] make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(k) For the purposes of paragraph (j)(2) of this section, a network gap exception means an insurer's approval for an insured to receive care from a nonpreferred provider under the preferred provider benefit level because access to care through a preferred provider is not available within network adequacy standards. When facilitating care as required under paragraph (j)(2) of this section, a recommended physician or provider is reasonably available if they are:

(1) a nonpreferred provider within the network adequacy standards in §3.3704(f) of this title; or

(2) a preferred or nonpreferred provider outside of the network adequacy standards in §3.3704(f) of this title, only if the distance to reach the recommended physician or provider is not more than 15% farther than the distance to reach the nearest available physician or provider.

(l) An [~~A local market~~] access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, and includes the information specified in §3.3712(c)(2)(E)(iii) of this title.

[~~(m) An insurer must submit a local market access plan established pursuant to this section as a part of the annual report on network adequacy required under §3.3709 of this title (relating to Annual Network Adequacy Report).~~]

[~~(n) An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital based services is required to comply with §3.3705(p) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations). The insurer is required to designate such plan as having a "Limited Hospital Care Network".~~]

§3.3708. Payment of Certain Out-of-Network [~~Basic Benefit~~] Claims [~~and Related Disclosures~~].

(a) For an out-of-network claim for which the insured is protected from balance billing under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, or when no preferred provider is reasonably available, an insurer must pay the claim at the preferred level of coverage, including with respect to any applicable copay, coinsurance, deductible, or maximum out-of-pocket amount. The insurer must pay the claim according to the following payment standards:

(1) for emergency care and post-emergency stabilization care, the applicable payment standards are under §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care;

(2) for certain care provided in a health care facility, the applicable payment standards are under §1301.164, concerning Out-of-Network Facility-Based Providers;

(3) for certain diagnostic imaging or laboratory services performed in connection with care provided by a preferred provider, the applicable payment standards are under §1301.165, concerning Out-of-Network Diagnostic Imaging Provider or Laboratory Service Provider;

(4) until August 31, 2025, for certain services and transports provided by an emergency medical services provider, other than air ambulance, the applicable payment standards are under §1301.166, concerning Out-of-Network Emergency Medical Services Provider; and

(5) for services provided by a nonpreferred provider when a preferred provider is not available within the network adequacy standards established in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), the applicable payment standards are under Insurance Code §1301.005, concerning Availability of Preferred Providers; Service Area Limitations, and Insurance Code §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services.

[~~(a) An insurer must comply with the requirements of subsections (b) and (c) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:~~]

[~~(1) requiring emergency care;~~]

[~~(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and~~]

[~~(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.~~]

(b) If medically necessary covered services are not available through a preferred provider within the network adequacy standards under §3.3704(f) of this title (relating to Network Requirements) and the services are not subject to subsection (a)(1) - (4) of this section, the insurer must:

(1) for a preferred or exclusive provider benefit plan:

(A) facilitate the insured's access to care consistent with the access plan and documented plan procedures specified in §3.3707(j) of this title (relating to Waiver Due to Failure to Contract in Local Markets); and

(B) inform the insured that:

(i) the out-of-network care the insured receives for the identified services will be covered under the preferred level of coverage with respect to any applicable cost-sharing and will not be subject to any service area limitation;

(ii) the insured can choose to use a physician or provider recommended by the insurer without being responsible for an

amount in excess of the cost sharing under the plan, or an alternative nonpreferred provider chosen by the insured, with the understanding that the insured will be responsible for any balance bill amount the alternative nonpreferred provider may charge in excess of the insurer's reimbursement rate; and

(iii) the amount the insurer will reimburse for the anticipated services.

(2) for an exclusive provider plan:

(A) process a referral to a nonpreferred provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation; and

(B) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of physician or provider to whom a referral is requested under subparagraph (A) of this paragraph before the insurer may deny the referral;

[(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:]

[(1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;]

[(2) pay the claim at the preferred benefit coinsurance level; and]

[(3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.]

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

[(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;]

(1) [(2)] if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(2) [(3)] is updated no less than once per year;

(3) [(4)] does not use data that is more than three years old; and

(4) [(5)] is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) Except for an exclusive provider benefit plan, an [An] insurer is required to pay all covered out-of-network [basic] benefits for services obtained from health care providers or physicians at least at the plan's out-of-network [basic] benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan must [shall] not be a basis for denial of a claim.

(e) Consistent with Insurance Code §1301.140, concerning Out-of-Pocket Expense Credit, an insurer must establish a procedure by which an insured may:

(1) identify the average discounted rate paid by the insurer to a given type of preferred provider for a covered service or supply;

(2) obtain a covered service or supply from a nonpreferred provider; and

(3) claim a credit, under the preferred level of coverage, toward the insured's deductible and annual maximum out-of-pocket amount, for the amount paid by the insured to the nonpreferred provider, if:

(A) the amount the insured paid to the nonpreferred provider is less than the insurer's average discounted rate;

(B) the insurer has not paid a claim for the service or supply; and

(C) the insured submits the documentation identified by the insurer, according to the process set forth on the insurer's website and in the insured's certificate of insurance.

[(e) When services are rendered to an insured by a nonpreferred hospital-based physician in an in-network hospital and the difference between the allowed amount and the billed charge is at least $500, the insurer must include a notice on the applicable explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider under Insurance Code Chapter 1467 and may obtain more information at www.tdi.texas.gov/consumer/epmmediation.html. An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation. In this paragraph, "facility-based physician" has the meaning given to it by §21.5003(6) of this title (relating to Definitions).]

(f) An insurer must cover a clinician-administered drug under the preferred level of coverage if it meets the criteria under Insurance Code §1369.764, concerning Certain Limitations on Coverage of Clinician-Administered Drugs Prohibited, even if it is dispensed by a nonpreferred provider.

[(f) This section does not apply to an exclusive provider benefit plan.]

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. On [An insurer must file a network adequacy report with the department on] or before April 1 of each year and prior to marketing any plan in a new service area, an insurer must submit a network adequacy report for each network to be used with a preferred or exclusive provider benefit plan. The network adequacy report must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(2) the network configuration information specified in §3.3712 of this title (relating to Network Configuration Filings);

[(1) the trade name of each preferred provider benefit plan in which insureds currently participate];

[(2) the applicable service area of each plan; and]

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers); and[.]

(4) if applicable, the waiver request and access plan information as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) - (7) [~~(6)~~] of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The report must include the number of:

(1) insureds served by the network in the most recent calendar year and the number of insureds projected to be served by the network in the upcoming calendar year;

(2) total complaints;

[~~(1) claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;~~]

[~~(2) claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;~~]

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for out-of-network [~~basic~~] benefits or concerning balance billing;

(5) complaints [~~by insureds~~] relating to the availability of preferred providers; [~~and~~]

(6) complaints [~~by insureds~~] relating to the accuracy of preferred provider listings; and [.]

(7) actuarial data on the current and projected utilization of each type of physician or provider within each region, including:

(A) the current and projected number of preferred providers of each specialty type;

(B) claims data for the most recent calendar year, including:

(i) the number of preferred provider claims;

(ii) the number of claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(iii) the number of claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(iv) the number of unique enrollees with one or more claims; and

(v) the number of unique providers with one or more claims.

(d) Filing the report. The annual report required under this section must be submitted electronically in SERFF or another electronic method that is [~~in a format~~] acceptable to the department using the annual network adequacy report form available at www.tdi.texas.gov. [~~Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following email address: Life-Health@tdi.texas.gov.~~]

(e) Exceptions. This section does not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's network and any [~~local market~~] access plan supporting the network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered under [~~pursuant to~~] the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more [~~of the following~~] sanctions under [~~pursuant to~~] the authority of the commissioner in Insurance Code Chapters 82, concerning Sanctions, and 83, concerning Emergency Cease and Desist Orders, including [~~to issue cease and desist orders~~]:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and [~~and/or~~]

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty under [~~pursuant to~~] the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

§3.3711. Geographic Regions.

For the purposes of this subchapter, the [~~The~~] 11 Texas geographic regions that an insurer is required to use for reporting data under §3.3709 of this title (relating to Annual Network Adequacy Report [~~permitted to use for purposes of defining a smaller than statewide service area as described in §3.3704(g)(1) of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers)~~] are as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, composed [~~comprised~~] of the following counties: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, and Yoakum; [~~ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054, 79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110, 79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;~~]

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, composed [~~comprised~~] of the following counties: Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton, Wichita, Wilbarger, and Young; [~~ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464, 76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227, 79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;~~]

(3) Region 3--Metroplex, including Fort Worth and Dallas, composed [~~comprised~~] of the following counties: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise; [~~ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062, 75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138, 75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180, 75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211, 75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001, 76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108, 76109, 76110, 76111, 76112, 76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;~~]

(4) Region 4--Northeast Texas, including Tyler, composed [~~comprised~~] of the following counties: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, and Wood; [~~ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450, 75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637, 75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651, 75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;~~]

(5) Region 5--Southeast Texas, including Beaumont, composed [~~comprised~~] of the following counties: Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler; [~~ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969, 75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664,~~

77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;]

(6) Region 6--Gulf Coast, including Houston and Huntsville, composed [comprised] of the following counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton; [ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255, 77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304, 77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365, 77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583, 77584, 77586, 77587, 77588, 77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;]

(7) Region 7--Central Texas, including Austin and Waco, composed [comprised] of the following counties: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, and Williamson; [ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539, 76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606, 78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615, 78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721, 78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;]

(8) Region 8--South Central Texas, including San Antonio, composed [comprised] of the following counties: Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala; [ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029, 78039, 78050, 78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219, 78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291,

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(9) Region 9--West Texas, including Midland, Odessa, and San Angelo composed [~~comprised~~] of the following counties: Andrews, Borden, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Loving, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, and Winkler; [~~ZIP Coded areas:~~ ~~76820,~~ ~~76825,~~ ~~76836,~~ ~~76837,~~ ~~76841,~~ ~~76842,~~ ~~76848,~~ ~~76849,~~ ~~76852,~~ ~~76854,~~ ~~76855,~~ ~~76856,~~ ~~76858,~~ ~~76859,~~ ~~76862,~~ ~~76866,~~ ~~76869,~~ ~~76872,~~ ~~76874,~~ ~~76886,~~ ~~76887,~~ ~~76901,~~ ~~76902,~~ ~~76903,~~ ~~76904,~~ ~~76905,~~ ~~76906,~~ ~~76908,~~ ~~76909,~~ ~~76930,~~ ~~76932,~~ ~~76933,~~ ~~76934,~~ ~~76935,~~ ~~76936,~~ ~~76937,~~ ~~76939,~~ ~~76940,~~ ~~76941,~~ ~~76943,~~ ~~76945,~~ ~~76949,~~ ~~76950,~~ ~~76951,~~ ~~76953,~~ ~~76955,~~ ~~76957,~~ ~~76958,~~ ~~78851,~~ ~~79331,~~ ~~79342,~~ ~~79359,~~ ~~79360,~~ ~~79377,~~ ~~79511,~~ ~~79701,~~ ~~79702,~~ ~~79703,~~ ~~79704,~~ ~~79705,~~ ~~79706,~~ ~~79707,~~ ~~79708,~~ ~~79710,~~ ~~79711,~~ ~~79712,~~ ~~79713,~~ ~~79714,~~ ~~79718,~~ ~~79719,~~ ~~79720,~~ ~~79721,~~ ~~79730,~~ ~~79731,~~ ~~79733,~~ ~~79735,~~ ~~79738,~~ ~~79739,~~ ~~79740,~~ ~~79741,~~ ~~79742,~~ ~~79743,~~ ~~79744,~~ ~~79745,~~ ~~79748,~~ ~~79749,~~ ~~79752,~~ ~~79754,~~ ~~79755,~~ ~~79756,~~ ~~79758,~~ ~~79759,~~ ~~79760,~~ ~~79761,~~ ~~79762,~~ ~~79763,~~ ~~79764,~~ ~~79765,~~ ~~79766,~~ ~~79768,~~ ~~79769,~~ ~~79770,~~ ~~79772,~~ ~~79776,~~ ~~79777,~~ ~~79778,~~ ~~79780,~~ ~~79781,~~ ~~79782,~~ ~~79783,~~ ~~79785,~~ ~~79786,~~ ~~79788,~~ ~~79789,~~ ~~and~~ ~~79848;~~]

(10) Region 10--Far West Texas, including El Paso, composed [~~comprised~~] of the following counties: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, and Presidio; [~~ZIP Coded areas:~~ ~~79734,~~ ~~79821,~~ ~~79830,~~ ~~79831,~~ ~~79832,~~ ~~79834,~~ ~~79835,~~ ~~79836,~~ ~~79837,~~ ~~79838,~~ ~~79839,~~ ~~79842,~~ ~~79843,~~ ~~79845,~~ ~~79846,~~ ~~79847,~~ ~~79849,~~ ~~79851,~~ ~~79852,~~ ~~79853,~~ ~~79854,~~ ~~79855,~~ ~~79901,~~ ~~79902,~~ ~~79903,~~ ~~79904,~~ ~~79905,~~ ~~79906,~~ ~~79907,~~ ~~79908,~~ ~~79910,~~ ~~79911,~~ ~~79912,~~ ~~79913,~~ ~~79914,~~ ~~79915,~~ ~~79916,~~ ~~79917,~~ ~~79918,~~ ~~79920,~~ ~~79922,~~ ~~79923,~~ ~~79924,~~ ~~79925,~~ ~~79926,~~ ~~79927,~~ ~~79928,~~ ~~79929,~~ ~~79930,~~ ~~79931,~~ ~~79932,~~ ~~79934,~~ ~~79935,~~ ~~79936,~~ ~~79937,~~ ~~79938,~~ ~~79940,~~ ~~79941,~~ ~~79942,~~ ~~79943,~~ ~~79944,~~ ~~79945,~~ ~~79946,~~ ~~79947,~~ ~~79948,~~ ~~79949,~~ ~~79950,~~ ~~79951,~~ ~~79952,~~ ~~79953,~~ ~~79954,~~ ~~79955,~~ ~~79958,~~ ~~79960,~~ ~~79961,~~ ~~79968,~~ ~~79976,~~ ~~79978,~~ ~~79980,~~ ~~79990,~~ ~~79995,~~ ~~79996,~~ ~~79997,~~ ~~79998,~~ ~~79999,~~ ~~88510,~~ ~~88511,~~ ~~88512,~~ ~~88513,~~ ~~88514,~~ ~~88515,~~ ~~88516,~~ ~~88517,~~ ~~88518,~~ ~~88519,~~ ~~88520,~~ ~~88521,~~ ~~88523,~~ ~~88524,~~ ~~88525,~~ ~~88526,~~ ~~88527,~~ ~~88528,~~ ~~88529,~~ ~~88530,~~ ~~88531,~~ ~~88532,~~ ~~88533,~~ ~~88534,~~ ~~88535,~~ ~~88536,~~ ~~88538,~~ ~~88539,~~ ~~88540,~~ ~~88541,~~ ~~88542,~~ ~~88543,~~ ~~88544,~~ ~~88545,~~ ~~88546,~~ ~~88547,~~ ~~88548,~~ ~~88549,~~ ~~88550,~~ ~~88553,~~ ~~88554,~~ ~~88555,~~ ~~88556,~~ ~~88557,~~ ~~88558,~~ ~~88559,~~ ~~88560,~~ ~~88561,~~ ~~88562,~~ ~~88563,~~ ~~88565,~~ ~~88566,~~ ~~88567,~~ ~~88568,~~ ~~88569,~~ ~~88570,~~ ~~88571,~~ ~~88572,~~ ~~88573,~~ ~~88574,~~ ~~88575,~~ ~~88576,~~ ~~88577,~~ ~~88578,~~ ~~88579,~~ ~~88580,~~ ~~88581,~~ ~~88582,~~ ~~88583,~~ ~~88584,~~ ~~88585,~~ ~~88586,~~ ~~88587,~~ ~~88588,~~ ~~88589,~~ ~~88590,~~ ~~and~~ ~~88595;~~] and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, composed [~~comprised~~] of the following counties: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, and Zapata. [~~ZIP Coded areas:~~ ~~77950,~~ ~~77990,~~ ~~78007,~~ ~~78022,~~ ~~78040,~~ ~~78041,~~ ~~78042,~~ ~~78043,~~ ~~78044,~~ ~~78045,~~ ~~78046,~~ ~~78049,~~ ~~78060,~~ ~~78067,~~ ~~78071,~~ ~~78072,~~ ~~78075,~~ ~~78076,~~ ~~78102,~~ ~~78104,~~ ~~78125,~~ ~~78142,~~ ~~78145,~~ ~~78146,~~ ~~78162,~~ ~~78330,~~ ~~78332,~~ ~~78333,~~ ~~78335,~~ ~~78336,~~ ~~78338,~~ ~~78339,~~ ~~78340,~~ ~~78341,~~ ~~78342,~~ ~~78343,~~ ~~78344,~~ ~~78347,~~ ~~78349,~~ ~~78350,~~ ~~78351,~~ ~~78352,~~ ~~78353,~~ ~~78355,~~ ~~78357,~~ ~~78358,~~ ~~78359,~~ ~~78360,~~ ~~78361,~~ ~~78362,~~ ~~78363,~~ ~~78364,~~ ~~78368,~~ ~~78369,~~ ~~78370,~~ ~~78371,~~ ~~78372,~~ ~~78373,~~ ~~78374,~~ ~~78375,~~ ~~78376,~~ ~~78377,~~ ~~78379,~~ ~~78380,~~ ~~78381,~~ ~~78382,~~ ~~78383,~~ ~~78384,~~ ~~78385,~~ ~~78387,~~ ~~78389,~~ ~~78390,~~ ~~78391,~~ ~~78393,~~ ~~78401,~~ ~~78402,~~ ~~78403,~~ ~~78404,~~ ~~78405,~~ ~~78406,~~ ~~78407,~~ ~~78408,~~ ~~78409,~~ ~~78410,~~ ~~78411,~~ ~~78412,~~ ~~78413,~~ ~~78414,~~ ~~78415,~~ ~~78416,~~ ~~78417,~~ ~~78418,~~ ~~78419,~~ ~~78426,~~ ~~78427,~~ ~~78460,~~ ~~78461,~~ ~~78463,~~ ~~78465,~~ ~~78466,~~ ~~78467,~~ ~~78468,~~ ~~78469,~~ ~~78470,~~ ~~78471,~~ ~~78472,~~ ~~78473,~~ ~~78474,~~ ~~78475,~~ ~~78476,~~ ~~78477,~~ ~~78478,~~ ~~78480,~~ ~~78501,~~ ~~78502,~~ ~~78503,~~ ~~78504,~~ ~~78505,~~ ~~78516,~~ ~~78520,~~ ~~78521,~~ ~~78522,~~ ~~78523,~~ ~~78526,~~ ~~78535,~~ ~~78536,~~ ~~78537,~~ ~~78538,~~ ~~78539,~~ ~~78540,~~ ~~78541,~~ ~~78543,~~ ~~78545,~~ ~~78547,~~ ~~78548,~~ ~~78549,~~ ~~78550,~~ ~~78551,~~ ~~78552,~~ ~~78553,~~ ~~78557,~~ ~~78558,~~ ~~78559,~~ ~~78560,~~ ~~78561,~~ ~~78562,~~ ~~78563,~~ ~~78564,~~ ~~78565,~~ ~~78566,~~ ~~78567,~~ ~~78568,~~ ~~78569,~~ ~~78570,~~ ~~78572,~~ ~~78573,~~ ~~78574,~~ ~~78575,~~ ~~78576,~~ ~~78577,~~ ~~78578,~~ ~~78579,~~ ~~78580,~~ ~~78582,~~ ~~78583,~~ ~~78584,~~ ~~78585,~~ ~~78586,~~ ~~78588,~~ ~~78589,~~ ~~78590,~~ ~~78591,~~ ~~78592,~~ ~~78593,~~ ~~78594,~~ ~~78595,~~ ~~78596,~~ ~~78597,~~ ~~78598,~~ ~~and~~ ~~78599.~~]

§3.3712. Network Configuration Filings.

(a) An insurer must submit network configuration information as specified in this section in connection with a request for a waiver under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), an annual network adequacy report required under §3.3709 of this title (relating to Annual Network Adequacy Report), or an application for a network modification under §3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications).

(b) A network configuration filing must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(c) A network configuration filing must contain the following items.

(1) Provider listing data. The insurer must use the provider listings form available at www.tdi.texas.gov to provide a comprehensive searchable and sortable listing of physicians and health care providers in the plan's network that includes:

(A) information about the insurer, including the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(B) information about each preferred provider, including:

(i) the preferred provider's name, address of practice location, county, and telephone number;

(ii) the provider's national provider identifier (NPI) number and Texas license number;

(iii) the provider's specialty type or facility type, as applicable, using the categories specified in the form; and

(iv) whether the provider offers telehealth; and

(C) information about a preferred provider that is not a facility, including information on the preferred provider's facility privileges.

(2) Network compliance analysis. The insurer must use the network compliance and waiver request form available at www.tdi.texas.gov to provide a listing of each county in the insurer's service area and data regarding network compliance for each county, including:

(A) the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form;

(B) information indicating whether the network adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) are met with respect to each type of physician or provider, including specifying the nature of

the deficiency (such as insufficient providers, insufficient choice, or deficient appointment wait times);

(C) if the network adequacy standards are not met for a given type of physician or provider, a waiver request and an access plan consistent with §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), including an explanation of:

(i) the reason the waiver is needed, including whether the waiver is needed because of an insufficient number of physicians or providers available within the network adequacy standards, or because of a failure to contract with available providers;

(ii) if the waiver is needed because of a failure to contract with available providers, each year for which the waiver has previously been approved, beginning with 2024;

(iii) the total number of currently practicing physicians or providers that are located within each county and the source of this information;

(iv) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services when no preferred provider is available within the network adequacy standards, including procedures to coordinate care to limit the likelihood of balance billing, consistent with the procedures established in §3.3707(j) of this title; and

(v) actions to eliminate network adequacy gaps and mitigate the need for future waivers.

(D) except for a network offered in connection with an exclusive provider benefit plan, an insurer must include a description of how the insurer provides access to different types of facilities, as required by Insurance Code §1301.0055(b)(6), concerning Network Adequacy Standards.

(3) Online provider listing. The insurer must include a link to the online provider listing made available to insureds and a pdf copy of the provider listing that is made available to insureds that request a nonelectronic version.

(4) Access plan for unforeseen network gaps. The insurer must include a copy of the access plan required in §3.3707(m) of this title, which applies to any unforeseen circumstance in which an insured is unable to access covered health care services within the network adequacy standards provided in §3.3704 of this title.

(d) The information submitted as required under this section is considered public information under Government Code Chapter 552, concerning Public Information, and the insurer may not submit the provider listings form or network compliance and waiver request form in a manner that precludes the public release of the information. The department will use the data submitted under this section to publish network data consistent with Insurance Code §§1301.0055(a)(3), concerning Network Adequacy Standards, 1301.00565(g), concerning Public Hearing on Network Adequacy Standards Waivers, and 1301.009, concerning Annual Report.

§3.3713. County Classifications for Maximum Time and Distance Standards.

(a) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(c), concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, the following counties are classified as a large metro county: Bexar, Collin, Dallas, Harris, Tarrant, and Travis.

(b) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(d), the following counties are classified as a metro county: Angelina, Bastrop, Bell, Bowie, Brazoria, Brazos, Cameron, Comal, Denton, Ector, Ellis, El Paso, Fort Bend, Galveston, Grayson, Gregg, Guadalupe, Hays, Hidalgo, Hood, Hunt, Jefferson, Johnson, Kaufman, Lubbock, McLennan, Midland, Montgomery, Nueces, Orange, Parker, Potter, Randall, Rockwall, San Patricio, Smith, Taylor, Victoria, Waller, Webb, Wichita, and Williamson.

(c) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(e), the following counties are classified as a micro county: Anderson, Aransas, Burnet, Caldwell, Camp, Chambers, Cherokee, Coryell, Hardin, Harrison, Henderson, Kendall, Kerr, Lamar, Liberty, Maverick, Medina, Nacogdoches, Navarro, Polk, Rains, Rusk, Starr, Titus, Tom Green, Upshur, Van Zandt, Walker, Washington, Wilson, Wise, and Wood.

(d) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(f), the following counties are classified as a rural county: Andrews, Atascosa, Austin, Bandera, Bee, Blanco, Bosque, Brown, Burleson, Calhoun, Callahan, Cass, Colorado, Comanche, Cooke, Dawson, Deaf Smith, Delta, DeWitt, Eastland, Erath, Falls, Fannin, Fayette, Franklin, Freestone, Frio, Gaines, Gillespie, Gonzales, Gray, Grimes, Hale, Hill, Hockley, Hopkins, Houston, Howard, Hutchinson, Jackson, Jasper, Jim Wells, Jones, Karnes, Kleberg, Lamb, Lampasas, Lavaca, Lee, Leon, Limestone, Live Oak, Llano, Madison, Marion, Matagorda, Milam, Montague, Moore, Morris, Newton, Nolan, Ochiltree, Palo Pinto, Panola, Parmer, Red River, Robertson, Sabine, San Augustine, San Jacinto, Scurry, Shelby, Somervell, Stephens, Terry, Trinity, Tyler, Uvalde, Val Verde, Ward, Wharton, Wilbarger, Willacy, Young, and Zapata.

(e) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(g), the following counties are classified as a county with extreme access considerations: Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brooks, Carson, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dickens, Dimmit, Donley, Duval, Edwards, Fisher, Floyd, Foard, Garza, Glasscock, Goliad, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hudspeth, Irion, Jack, Jeff Davis, Jim Hogg, Kenedy, Kent, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Lynn, McCulloch, McMullen, Martin, Mason, Menard, Mills, Mitchell, Motley, Oldham, Pecos, Presidio, Reagan, Real, Reeves, Refugio, Roberts, Runnels, San Saba, Schleicher, Shackelford, Sherman, Sterling, Stonewall, Sutton, Swisher, Terrell, Throckmorton, Upton, Wheeler, Winkler, Yoakum, and Zavala.

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

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304351
Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

DIVISION 2. APPLICATION, EXAMINATION, AND ~~EXCLUSIVE PROVIDER BENEFIT~~ PLAN REQUIREMENTS

28 TAC §§3.3720, 3.3722, 3.3723

STATUTORY AUTHORITY. TDI proposes amendments to §§3.3720, 3.3722, and 3.3723 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

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. The proposed amendments to §3.3722 implement Insurance Code Chapter 1301.

§3.3720. Preferred and Exclusive Provider Benefit Plan Requirements.

Sections 3.3721 [~~- 3.3723~~] of this title (relating to Preferred and Exclusive Provider Benefit Plan Network Approval Required), 3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications), and 3.3723 of this title (relating to Examinations) [~~, Application for Preferred and Exclusive Provider Benefit Plan Approval and Qualifying Examination, and Examinations)~~] apply to preferred and exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, in commercial markets. Section 3.3724 [~~Sections 3.3274 - 3.3725~~] of this title (relating to Quality Improvement Program) applies [~~and Payment of Certain Out-of-Network Claims) apply~~] only to exclusive provider benefit plans offered under [~~pursuant to~~] Insurance Code Chapter 1301 in commercial markets.

§3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer a preferred or exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance as specified on the department's website and use the [~~. A~~] form titled Application for Approval of Provider Benefit Plan, which is available [~~on the department's website~~] at www.tdi.texas.gov/forms. [~~An insurer may use this form to prepare the application.~~]

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, the applicant must submit a complete new page [~~must be submitted~~] with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) - (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the preferred or exclusive provider benefit plan.

(5) The applicant must provide a description and a map of the service area, with key and scale, identifying the county or counties [~~area~~] to be served [~~by geographic region(s), county(ies), or ZIP code(s)~~]. If the map is in color, the original and all copies must also be in color.

(6) The applicant must provide a list of all plan documents and each document's associated form filing ID number or the form number of each plan document that is pending the department's approval or review.

(7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer's corporate president, corporate secretary, or the president's or secretary's authorized representative that the physician and provider contracts applicable to services provided under the preferred or exclusive provider benefit plan comply with the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter.

(8) The applicant, if applying for approval of an exclusive provider benefit plan offered under [~~pursuant to~~] Insurance Code Chapter 1301 in commercial markets, must provide a description of the quality improvement program and work plan that includes a process for physician [~~medical peer~~] review required by Insurance Code §1301.0051, concerning Exclusive Provider Benefit Plans: Quality Improvement and Utilization Management, and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

(9) The applicant must provide network configuration information, as specified in §3.3712 of this title (relating to Network Configuration Filings). [~~including:~~]

[~~(A) maps for each specialty demonstrating the location and distribution of the physician and provider network within the pro-~~

posed service area by geographic region(s), county(ies) or ZIP code(s); and]

[(B) lists of:]

[(i) physicians and individual providers who are preferred providers, including license type and specialization and an indication of whether they are accepting new patients; and]

[(ii) institutional providers that are preferred providers.]

[(C) For each health care provider that is a facility included in the list under subparagraph (B) of this paragraph, the applicant must:]

[(i) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;]

[(ii) under each heading described by clause (i) of this subparagraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;]

[(iii) for the facility and each facility-based physician described by clause (ii) of this subparagraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician, or facility-based physician group;]

[(iv) for each facility-based physician described by clause (ii) of this subparagraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices; and]

[(v) include the facility in a listing of all facilities and indicate:]

[(I) the name of the facility;]

[(II) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and]

[(III) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.]

[(D) The list required by subparagraph (B) of this paragraph must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group.]

(10) The applicant [, if applying for approval of an exclusive provider benefit plan offered pursuant to Insurance Code Chapter 1301 in commercial markets,] must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3707(k) of this title (relating to Waiver Due to Failure to Contract in Local Markets) and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims). [§3.3725(a) of this title (relating to Payment of Certain Out-of-Network Claims) and that the policy contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement to provide items or services to insureds, the provisions and procedures for coverage of emergency care services as set forth in §3.3725 of this title.]

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer in accordance with [pursuant to] subsection (c)(12) of this section:

(1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program) if the applicant is applying for approval of an exclusive provider benefit plan offered under [pursuant to] Insurance Code Chapter 1301 in commercial markets;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

(3) network configuration information as outlined in §3.3712 of this title that demonstrates compliance with network adequacy requirements described in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) [demonstrating adequacy of the provider network, as outlined in subsection (c)(9) of this section], and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

(4) credentialing files;

(5) all written materials to be presented to prospective insureds that discuss the provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

(6) the policy and certificate of insurance; and

(7) a complaint log that is categorized and completed in accordance [accord] with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file a network configuration filing as specified in §3.3712 of this title [an application] for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area. If any insured will be nonrenewed as a result of a service area reduction, the insurer must comply with the requirements under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions).

(2) In accordance with [Pursuant to] paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

(B) forms of contracts, as described in subsection (c) of this section; or

(C) network configuration information, as required by §3.3712 of this title [subsection (c)(9) of this section].

[(3) Before the department grants approval of a service area expansion or reduction application for an exclusive provider benefit plan offered pursuant to Insurance Code Chapter 1301 in commercial

~~markets, the insurer must comply with the requirements of §3.3724 of this title in the existing service areas and in the proposed service areas.]~~

(3) [~~(4)~~] An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

(f) Exceptions. Paragraphs (c)(9) and (d)(3) and subsection (e) of this section do not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3723. Examinations.

(a) The Commissioner may conduct an examination relating to a preferred or exclusive provider benefit plan as often as the Commissioner considers necessary, but no less than once every three years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted under [~~pursuant to~~] Insurance Code Chapter 401, Subchapter B, concerning Examination of Carriers; Insurance Code Chapter 751, concerning Market Conduct Surveillance; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; and §7.83 of this title (relating to Appeal of Examination Reports).

(c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

(d) On request of the Commissioner, an insurer must provide to the Commissioner a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider. Documentation provided to the Commissioner under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056, concerning Examinations and Fees.

(e) The Commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under Insurance Code Title 2, Subtitle B, concerning Discipline and Enforcement, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by the Occupations Code §151.002, concerning Definitions.

(f) The following documents must be available for review at the physical address designated by the insurer in accordance with [~~pursuant to~~] §3.3722(c)(12) of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes as required by §3.3724 of this title (relating to Quality Improvement Program) must be available for examinations of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in the commercial market;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and completed in accordance [~~accord~~] with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions);

(4) satisfaction surveys--any insured, physician, and provider satisfaction surveys, and any insured disenrollment and termination logs;

(5) network configuration information as required by §3.3712 [~~§3.3722(c)(9)~~] of this title (relating to Network Configuration Filings) demonstrating adequacy of the provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity.

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

Filed with the Office of the Secretary of State on November 21, 2023.

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Jessica Barta
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 676-6555

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28 TAC §3.3725

STATUTORY AUTHORITY. TDI proposes the repeal of §3.3725 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonably accessibility and availability of preferred provider services.

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. The proposed repeal of §3.3725 implements Insurance Code Chapter 1301.

§3.3725. Payment of Certain Out-of-Network Claims.

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

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General Counsel
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CHAPTER 7. CORPORATE AND FINANCIAL REGULATION
SUBCHAPTER B. INSURANCE HOLDING COMPANY SYSTEMS

28 TAC §7.216

The Texas Department of Insurance (TDI) proposes new 28 TAC §7.216, concerning a liquidity stress test framework for certain insurance companies. Section 7.216 implements House Bill 2839, 88th Legislature, 2023.

EXPLANATION. New §7.216 adopts a liquidity stress test framework and reporting requirements for certain insurers. HB 2839 adds new Insurance Code §823.0596, which requires the commissioner to adopt a liquidity stress test framework--including scope criteria and reporting templates--consistent with the framework published by the National Association of Insurance Commissioners (NAIC) and report it to the NAIC to facilitate the aggregation of results from the liquidity stress test filed with this and other states. HB 2839 was a biennial recommendation from TDI.

The liquidity stress test framework simulates large-scale asset sales in response to unexpected liquidity demands and assesses the potential impact of these sales on financial markets.

A secondary goal of the liquidity stress test implementation is to enhance monitoring of large life insurers that might be vulnerable to liquidity stress. Liquidity demands can be placed unexpectedly on an insurer that issues long-term cash-buildup products, particularly when cash and asset surrenders are experienced at greater-than-projected levels during widespread economic shifts. Elevated demand of cash payouts by customers can impact broader financial markets if those insurers are required to sell a significant amount of assets to meet demand.

New §7.216(a) provides the purpose of the section. New §7.216(b) provides that the liquidity stress test framework is adopted as published by the NAIC. New §7.216(c) specifies the scope criteria and thresholds applicable to the liquidity stress test framework. New §7.216(d) specifies that the ultimate controlling person of an insurer must submit the liquidity stress test framework filing using the appropriate reporting template in an electronic format. New §7.216(e) describes the exemption process. After consultation with other state insurance commissioners, the commissioner can exempt from the filing requirement a data year that an insurer would otherwise be required to submit under subsection (d) of this section. New §7.216(f) states that if there was a conflict between the liquidity stress test framework adopted by NAIC and the Insurance Code or TDI rules, including new §7.216, the Insurance Code or TDI rule takes precedence and in all respects controls.

This proposal arises out of rules, regulations, directives, or standards adopted by the NAIC. Under Insurance Code §36.004, TDI must consider whether authority exists to enforce or adopt it. In addition, under Insurance Code §36.007, an agreement that infringes on the authority of this state to regulate the business of insurance in this state has no effect unless the agreement is approved by the Texas Legislature. TDI has determined that neither Insurance Code §36.004 nor §36.007 prohibits the proposed rule because of Insurance Code §823.0596, requiring the adoption by rule of a liquidity stress test framework consistent with the framework published by the NAIC.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Mike Arendall, assistant chief analyst of the Financial Analysis Section, Financial Regulation Division, has determined that during each year of the first five years the proposed new section is in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the new section, other than that imposed by the statute. Mr. Arendall made this determination because the proposed new section does not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new section.

Mr. Arendall does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new section is in effect, Mr. Arendall expects that enforcing the proposed new section will have the public benefit of ensuring that TDI's rules conform to Insurance Code §823.0596 and the rule meets anticipated NAIC accreditation standard requirements. Insurers that meet the liquidity stress test framework scope criteria may incur additional monitoring and reporting costs to comply. However, these costs are attributable to the statute, which requires TDI to adopt a liquidity stress test framework, including scope criteria and reporting templates that are consistent with the framework published by the NAIC.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed new section will not have an adverse economic effect on small or micro businesses, or on rural communities. This is because the amendment does not impose any requirements beyond those required by the statute. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Any costs are attributable to the statute, which directs the commissioner to adopt the liquidity stress test framework. In addition, the proposed rule is necessary to implement Insurance Code §823.0596, as added by HB 2839.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new section is in effect, the proposed rule:

- 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 create a new regulation;

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

- will increase or decrease the number of individuals subject to the rule's applicability; and

- may positively 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 a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on January 8, 2024. Send your comments to ChiefClerk@tdi.texas.gov or 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 new §7.216 under Insurance Code §§823.012, 823.0596, and 36.001.

Insurance Code §823.012 states the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Insurance Code Chapter 823, including the conducting of business and proceedings under Insurance Code Chapter 823.

Insurance Code §823.0596 requires the commissioner to adopt by rule a liquidity stress test framework, including scope criteria and reporting templates, consistent with the framework published by the NAIC to facilitate the aggregation of results from the liquidity stress test filed with this and other states.

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 7.216 implements Insurance Code §823.0596.

§7.216. Liquidity Stress Test Framework.

(a) Purpose. This section specifies the requirements for the ultimate controlling person of an insurance holding company system to submit a liquidity stress test framework necessary to report information as required by Insurance Code §823.0596.

(b) Liquidity stress test framework. The commissioner adopts by reference the liquidity stress test framework as adopted and published by the National Association of Insurance Commissioners (NAIC). The liquidity stress test framework is available on the department's website.

(c) Scope criteria. The scope criteria are the designated criteria and thresholds described in the liquidity stress test framework as adopted by reference in subsection (b) of this section.

(d) Reporting template. The reporting template an insurer must use is described in the liquidity stress test framework as adopted in subsection (b) of this section.

(d) Filing. Using the reporting template described in the liquidity stress test framework adopted by reference in subsection (b) of this section, the ultimate controlling person of an insurer must submit a liquidity stress test framework filing on or before June 30 of each year, using the appropriate reporting template in an electronic format acceptable to TDI. The electronic filing address is provided on TDI's website at www.tdi.texas.gov.

(e) Exemption. Only after consultation with other state insurance commissioners will the commissioner exempt from the filing requirement a data year that an insurer would otherwise be required to submit under subsection (d) of this section.

(f) Conflicts. In the event of a conflict between the liquidity stress test framework adopted and published by the NAIC and the Insurance Code, any TDI rule, or any specific requirement of this section, the Insurance Code, TDI rule, or specific requirement of this section takes precedence and in all respects controls. The requirements of this section do not repeal, modify, or amend any TDI rule or any Insurance Code provision.

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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Jessica Barta
General Counsel
Texas Department of Insurance
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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION
SUBCHAPTER JJ. CIGARETTE, E-CIGARETTE, AND TOBACCO PRODUCTS REGULATION

34 TAC §3.1208

The Comptroller of Public Accounts proposes new §3.1208, concerning prohibited e-cigarette products. The new section implements House Bill 4758, 88th Legislature, 2023, which enacted Health and Safety Code, §161.0876 (Prohibited E-Cigarette Products).

The Texas Legislature has identified concerns that electronic cigarette ("e-cigarette") manufacturers have begun marketing their products to attract youth.

"Various e-cigarette manufacturers package e-cigarette products to appear nearly identical to popular candy, flavored juice boxes, and other edible treats. The similarity in packaging of e-cigarette products to children's snacks is a direct appeal from manufacturers to children, which entices them to consume these dangerous nicotine products. The CDC reports that 69 percent of youth are exposed to e-cigarette advertisement via retail stores, magazines, TV shows, movies, and the Internet. These mediums also use cartoon-like characters and celebrity imagery to appeal to youths. According to the CDC, in the 10-year period from 2011 to 2021, vaping rates among middle and high school student increased from 1.5 percent of youth to nearly 30 percent of youth using e-cigarettes. These deliberate and ongoing efforts considerably impact the consumption

rates of e-cigarettes among youth and require swift action. In 2018, the Department of State Health Services determined that e-cigarette use has reached epidemic status among teens." House Comm. on Pub. Health, Bill Analysis, Tex. C.S.H.B. 4758, 88th Leg., R.S. (2023).

The Legislature enacted Health and Safety Code, §161.0876 to reduce youth consumption of e-cigarettes by prohibiting the marketing, advertising, or sale of e-cigarette products in containers designed to appeal to minors. *Id.*

Subsection (a) provides definitions. Paragraph (1) defines "cartoon." Health and Safety Code, §161.0876 uses the term but does not define it. The comptroller derives this definition from the definition of "cartoon" in the Master Settlement Agreement entered into in November 1998 by four United States tobacco manufacturers and the attorneys general of 46 States. The Master Settlement Agreement is available at: https://www.naag.org/wp-content/uploads/2020/09/2019-01-MSA-and-Exhibits-Final.pdf (last visited November 27, 2023).

Paragraph (2) defines "celebrity." See, e.g., David Tan, *Much Ado About Evocation: A Cultural Analysis of "Well-Knownness" and the Right of Publicity,* 28 Cardozo Arts & Ent. L.J. 317, 340-41 (2010). The proposed definition is consistent with dictionary definitions of the term. For example, the Oxford English Dictionary defines "celebrity" as "{a} well-known or famous person; (now chiefly) *spec.* a person, esp. in entertainment or sport, who attracts interest from the general public and attention from the mass media." Oxford English Dictionary, https://www.oed.com/dictionary/celebrity_n?tab=meaning_and_use (last visited November 27, 2023). Dictionary.com defines "celebrity" to mean "a famous or well-known person." *Dictionary.com,* https://www.dictionary.com/browse/celebrity (last visited November 27, 2023).

Paragraph (3) defines "container" based upon the dictionary definition of the term. For example, Merriam Webster defines "container" as "a receptacle (such as a box or jar) for holding goods." *Merriam-Webster.com,* https://www.merriam-webster.com/dictionary/container (last visited November 27, 2023). Dictionary.com defines "container" as "anything that contains or can contain something, as a carton, box, crate, or can." *Dictionary.com,* https://www.dictionary.com/browse/container (last visited November 27, 2023). The proposed definition is consistent with the description of e-cigarette nicotine containers in Health and Safety Code, §161.0875 (Sale of E-cigarette Nicotine Containers), which provides that an e-cigarette nicotine container must satisfy the child-resistant effectiveness standards under 16 C.F.R. §1700.15(b)(1). Those federal standards, in turn, apply to "special packaging." The definition in paragraph (3) therefore provides that the term "container" includes the packaging of an e-cigarette product.

Paragraph (4) defines "e-cigarette" using the definition given in Health and Safety Code, §161.081(1-a) (Definitions).

Paragraph (5) defines "e-cigarette product" using the definition given in Health and Safety Code, §161.0876(a).

Paragraph (6) defines "food product." Health and Safety Code, §161.0876 uses the term but does not define it. The comptroller derives this definition from the definition of "food and food ingredients" in §3.293 of this title (relating to Food; Food Products; Meals; Food Service).

Paragraph (7) defines "minor" using the definition given in Health and Safety Code, §161.081(1-b).

Paragraph (8) defines "retailer." The definition is based on the definition given in Health and Safety Code, §161.081(4). The qualifier "coin-operated" is removed from the description of vending machines to better track the language in Tax Code, Chapters 154 (Cigarette Tax) and 155 (Cigars and Tobacco Products Tax), and to eliminate any confusion with coin-operated machines, which are regulated under the Occupations Code. In addition, because the comptroller does not permit e-cigarette vending machines, the term "e-cigarette" is deleted as a descriptor of vending machines.

Subsection (b) implements Health and Safety Code, §161.0876(b), which makes it an offense to market, advertise, sell, or cause to be sold an e-cigarette product if the product's container displays images or depictions aimed at minors, and §161.0901, which provides that the comptroller may take disciplinary action against a retailer who commits such an offense. Paragraph (1) provides specific examples of the types of depictions and images identified in §161.0876(b)(1) - (5). For example, Health and Safety Code, §161.0876(b)(1) provides that it is an offense to sell an e-cigarette product if the product's container "depicts a cartoon-like fictional character that mimics a character primarily aimed at entertaining minors." Subparagraph (A) adds that a superhero, video game character, or character from an animated television show may be a cartoon-like fictional character aimed at entertaining minors. Paragraph (2) cross-references §3.1204 of this title (relating to Administrative Remedies for Violations of Health and Safety Code, Chapter 161, Subchapter H or K).

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed new rule is in effect, the rule: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed new rule would benefit the public by conforming the rules to current statute. This rule is proposed under Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses or rural communities. The proposed new rule would have no significant fiscal impact on the state government, units of local government, or individuals. There would be no anticipated significant economic cost to the public.

You may submit comments on the proposal to Jenny Burleson, Director, Tax Policy Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: tp.rule.comments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

This section is proposed under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture), which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2 (State Taxation), and taxes, fees, or other charges which the comptroller administers under other law, and under Health and Safety Code, §161.0901 (Disciplinary Action Against Cigarette, E-Cigarette, and Tobacco Product Retailers),

which provides the comptroller with the authority to adopt rules to implement the section.

The section implements Health and Safety Code, §161.0876 (Prohibited E-Cigarette Products) and §161.0901 (Disciplinary Action Against Cigarette, E-Cigarette, and Tobacco Product Retailers).

§3.1208. Prohibited E-Cigarette Products.

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

(1) Cartoon--Any drawing or other depiction of an object, person, animal, creature, or any similar caricature that satisfies any of the following criteria:

(A) the use of comically exaggerated features;

(B) the attribution of human characteristics to animals, plants, or other objects, or the similar use of anthropomorphic technique; or

(C) the attribution of unnatural or extra-human abilities, such as imperviousness to pain or injury, X-ray vision, tunneling at very high speeds, or transformation.

(2) Celebrity--An individual well-known to a significant section of the public.

(3) Container--Any object used to hold an e-cigarette product, including, but not limited to, a pod, bottle, jar, box, wrapper, or other packaging.

(4) E-cigarette--An electronic cigarette or any other device that simulates smoking by using a mechanical heating element, battery, or electronic circuit to deliver nicotine or other substances to the individual inhaling from the device; or a consumable liquid solution or other material aerosolized or vaporized during the use of an electronic cigarette or other device described by this subdivision. The term does not include a prescription medical device unrelated to the cessation of smoking. The term also includes:

(A) a device described in paragraph (1) of this subsection regardless of whether the device is manufactured, distributed, or sold as an e-cigarette, e-cigar, or e-pipe or under another product name or description; and

(B) a component, part, or accessory for the device, regardless of whether the component, part, or accessory is sold separately from the device.

(5) E-cigarette product--Any substance containing nicotine from any source that is intended for use in an e-cigarette.

(6) Food product--A product intended for human consumption that is consumed for taste, aroma, or nutritional value. The term includes, but is not limited to, fruit, juice, candy, cookies, cereal, coffee, ice cream, soft drinks, and mint and other herbs.

(7) Minor--A person under 21 years of age.

(8) Retailer--a person who engages in the practice of selling cigarettes, e-cigarettes, or tobacco products to consumers and includes the owner of a cigarette or tobacco product vending machine. The term includes a retailer as defined by Tax Code, §154.001 (Definitions) or §155.001 (Definitions), and an e-cigarette retailer as defined by Health and Safety Code, §147.0001 (Definitions).

(b) Violations and Penalties.

(1) A person commits an offense if the person markets, advertises, sells, or causes to be sold an e-cigarette product, if the product's container:

(A) depicts a cartoon-like fictional character that mimics a character primarily aimed at entertaining minors, including a superhero, video game character, or character from an animated television show marketed to minors;

(B) imitates or mimics trademarks or trade dress of products that are or have been primarily marketed to minors, including products that are candy, bubble gum, cookies, cereals, juice boxes, or soft drinks;

(C) includes a symbol that is primarily used to market products to minors;

(D) includes an image of a celebrity; or

(E) includes an image that is or resembles a food product.

(2) A retailer is subject to disciplinary action as provided by §3.1204 of this title (relating to Administrative Remedies for Violations of Health and Safety Code, Chapter 161, Subchapter H) if the comptroller finds, after notice and an opportunity for a hearing, that an agent or employee of the retailer marketed, advertised, sold, or caused to be sold an e-cigarette product in violation of this section.

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

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Jenny Burleson
Director, Tax Policy Division
Comptroller of Public Accounts
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CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER I. VALUATION PROCEDURES

34 TAC §9.4038

The Comptroller of Public Accounts proposes new §9.4038, concerning definition of petroleum products. The new section replaces existing §9.4201, concerning definition of petroleum products, which the comptroller is proposing for repeal to improve the clarity and organization of Subchapter I. The section is also updated to better reflect the list of products that fall under this definition.

The definition in paragraph (14) is modified from its current form in order to hyphenate "kerosene-type," which is not currently hyphenated. The definitions are also expanded to incorporate the products of ethane, normal butane, isobtutane, and natural gasoline. No other changes are being made to the existing language of §9.4201.

The comptroller provides the definition of petroleum products to assist appraisal districts in the administration and implementation of Tax Code, §11.251 (Tangible Personal Property Exempt).

The products defined by this section are not exempt under the "freeport" exemption provided by Tax Code, §11.251 and Texas Constitution, Article VIII, Section 1-j.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed new rule is in effect, the rule: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed new rule would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed new rule would benefit the public by improving the organization and clarity of Subchapter I (Valuation Procedures.) There would be no anticipated significant economic cost to the public. The proposed new rule would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528, Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

The comptroller proposes the new section under Tax Code, §5.03 (Powers and Duties Generally), which provides the comptroller with the authority to adopt rules establishing minimum standards for the administration and operation of an appraisal district.

The new section implements Tax Code, §11.251 (Tangible Personal Property Exempt).

§9.4038. Definition of Petroleum Products.

For the purposes of administration and operation of appraisal districts, the term "liquid or gaseous materials that are the immediate derivatives of the refining of oil or natural gas," as used in the Tax Code, §11.251, means the following products:

(1) ethane;

(2) propane;

(3) butane;

(4) normal butane;

(5) isobutane;

(6) butane-propane;

(7) motor gasoline;

(8) natural gasoline;

(9) kerosene;

(10) home heating oil;

(11) diesel fuel;

(12) other middle distillates;

(13) aviation gasoline;

(14) kerosene-type jet fuel;

(15) naphtha-type jet fuel;

(16) fuel oil #4 for utility use;

(17) fuel oils #5, #6 for utility use;

(18) fuel oil #4 for nonutility use;

(19) fuel oils #5, #6 for nonutility use;

(20) bunker C;

(21) navy special;

(22) lubricants;

(23) special naphtha;

(24) solvent products; and

(25) crude oil.

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

Filed with the Office of the Secretary of State on November 27, 2023.

TRD-202304369
Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 475-2220

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34 TAC §9.4201

The Comptroller of Public Accounts proposes the repeal of §9.4201, concerning definition of petroleum products. The comptroller repeals existing §9.4201 in order to propose the adoption of a replacement §9.4038 to improve the organization of Subchapter I. The repeal of §9.4201 will be effective as of the date the new §9.4038 takes effect.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed rule repeal is in effect, the repeal: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed rule repeal would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed rule repeal would benefit the public by improving the clarity and organization of Subchapter I (Valuation Procedures.) There would be no anticipated significant economic cost to the public. The proposed rule repeal would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

The repeal is proposed under Tax Code, §5.03 (Powers and Duties Generally), which provides the comptroller with the authority to adopt rules establishing minimum standards for the administration and operation of an appraisal district.

The repeal implements Tax Code, §11.251 (Tangible Personal Property Exempt).

§9.4201. Definition of Petroleum Products.

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

Filed with the Office of the Secretary of State on November 27, 2023.

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Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 475-2220

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 3. RESPONSIBILITIES OF STATE FACILITIES

SUBCHAPTER D. TRAINING

40 TAC §§3.401 - 3.404

As required by Texas Government Code §531.0202(b), the Department of Aging and Disability Services (DADS) was abolished effective September 1, 2017, after all its functions were transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code §531.0201 and §531.02011. Rules of the former DADS are codified in Title 40, Part 1, and will be repealed or administratively transferred to Title 26, Health and Human Services, as appropriate. Until such action is taken, the rules in Title 40, Part 1 govern functions previously performed by DADS that have transferred to HHSC. Texas Government Code §531.0055, requires the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by the health and human services system, including rules in Title 40, Part 1. Therefore, the Executive Commissioner of HHSC proposes the repeal of rules in Title 40, Part 1, Chapter 3, Subchapter D, Training, comprising of §3.401, concerning Training for New Employees; §3.402, concerning Additional Training for Direct Support Professionals; §3.403, Refresher Training; and §3.404, Specialized Training for of a Forensic Facility Employee.

BACKGROUND AND PURPOSE

The purpose of the proposed repeals is to reflect the move of the state supported living centers from DADS to HHSC by moving HHSC rules from Texas Administrative Code (TAC) Title 40, Chapter 3, Subchapter D to 26 TAC Chapter 926 and consolidate HHSC rules. The new rules are proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

The repeal of 40 TAC Chapter 3, Subchapter D rules will delete the rules from 40 TAC and place updated rules in 26 TAC to reflect the transfer of functions from DADS to HHSC.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the repeals will be in effect, enforcing or administering the repeals 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 repeals will be in effect:

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

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

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

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

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

(6) the proposed repeals will repeal existing rules;

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

(8) the proposed repeals 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 because the repeals do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed repeals will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the repeals are in effect, the public benefit will be the removal of rules no longer associated with DADS from 40 TAC.

Trey Wood has also determined that for the first five years the repeals are in effect, there are no anticipated economic costs to persons who are required to comply with the repeals because the repeals do not impose a cost.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §555.024, which requires HHSC to provide certain training for employees of SSLCs and requires the Executive Commissioner to adopt rules for SSLCs to provide refresher trainings to direct care employees.

The repeals affect Texas Government Code §531.0055 and Texas Health and Safety Code §555.024.

§3.401. Training for New Employees.

§3.402 Additional Training for Direct Support Professionals.

§3.403 Refresher Training.

§3.404 Specialized Training for of a Forensic Facility Employee.

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304330
Karen Ray
Chief Counsel
Department of Aging and Disability Services
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 438-3049

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PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 700. CHILD PROTECTIVE SERVICES

SUBCHAPTER I. PURCHASED PROTECTIVE SERVICES TO PREVENT REMOVAL OR TO REUNIFY FAMILIES

40 TAC §700.905

The Department of Family and Protective Services (DFPS) proposes new §700.905 in Title 40, Texas Administrative Code (TAC), Chapter 700, Subchapter I, relating to Purchased Protective Services to Prevent Removal or to Reunify Families.

BACKGROUND AND PURPOSE

The Texas 88th Regular legislative session enacted House Bill 793 which requires DFPS to promulgate a rule requiring DFPS to reimburse a licensed or qualified provider in an amount equal to the average cost for the specific service from department contractors providing the service in the region the parent resides, from existing DFPS resources. This provision is codified at Texas Family Code §263.1021.

Chapter 263, Subchapter B of the Texas Family Code pertains to when the Department of Family and Protective Services (DFPS) has been court ordered the temporary managing conservator of a minor, and the parent, as a client is required to obtain services under a family service plan. A parent seeking services under a family service plan will be permitted to choose a licensed or qualified service provider that is not under contract with DFPS or an SSCC. Services obtained from a service provider selected by the parent must be designed to achieve the stated goals of the Family Plan of Service for a child in DFPS conservatorship and the service provider must certify whether the parent has satisfactorily completed the required service that is being sought for reimbursement.

SECTION-BY-SECTION SUMMARY

Proposed new §700.905: gives a summary of the rule, including that this rule relating to the reimbursement of noncontracted service providers are intended to further supplement and clarify Texas Family Code §263.1021; (a) defines words used in the bill and in the rule to clarify family plan of service, qualified and license providers; (b) requires Single Source Continuum Contract/Contractors (SSCC) to adopt their own reimbursement requirements; (c) requires the service provider, as opposed to the parent to seek reimbursement for the services; (d) allows services to be provided in-person or via electronic communication platform; (e) requires a service provider to bill Medicaid if the parent is a Medicaid beneficiary; and (f) lays out the basic requirements for a non-contracted service provider to be reimbursed, such as a licensed provider maintaining licensure, the timeline in which DFPS can reimburse, and that the service provider cannot be related by consanguinity or affinity to the parent receiving services.

FISCAL NOTE

Lea Ann Biggar, Chief Financial Officer of DFPS, has determined that for each year of the first five years that the section(s) will be in effect, there will not be fiscal implications to state and local governments as a result of enforcing and administering the section(s) as proposed. Implementation of this statute and rule would require DFPS to process payments manually within existing resources and without IT modifications at this time.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

Ms. Biggar has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rule will provide additional revenue for small, micro businesses or rural communities by allowing them to provide services to DFPS clients without having to go through the contracting process to become a certified vendor for the agency.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

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

There is no anticipated negative impact on local employment.

COSTS TO REGULATED PERSONS

Pursuant to subsection (c)(7) of Texas Government Code §2001.0045, the statute does not apply to a rule that is adopted by the Department of Family and Protective Services

PUBLIC BENEFIT

Ms. Biggar has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the section(s). The public benefit anticipated will be a positive effect on small, or micro-businesses or rural communities because the proposed changes will provide additional revenue for small, micro businesses or rural communities by allowing them to provide services to DFPS clients without having to go through the contracting process to become a certified vendor for the agency. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Comments and questions on this proposal must be submitted within 30 days of publication of the proposal in the *Texas Register.* Electronic comments and questions may be submitted to RULES@dfps.state.tx.us. Hard copy comments may be submitted to the DFPS Rules Coordinator, Legal Services Sanjuanita Maltos, Department of Family and Protective Services E-611, P.O. Box 149030, Austin, Texas 78714-9030.

STATUTORY AUTHORITY

The new rule section 700.905 is authorized by Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services Commissioner shall adopt rules for the operation and provision of services by the department.

CROSS REFERENCE TO STATUTES

The new rule implements Texas Family Code §263.1021.

§700.905. Reimbursement of Noncontracted Service Providers.

(a) A parent who is required to complete a Family Service Plan may obtain services from a qualified or licensed noncontracted service provider, and this provider may be reimbursed by DFPS in an amount equal to the average cost for the specific service from DFPS contractors providing the service in the region, where the parent resides. Only services where the parent is the direct client of the service provider are eligible for reimbursement. In addition, the rules relating to the reimbursement of noncontracted service providers are intended to further supplement and clarify Texas Family Code §263.1021. This rule is operable to the extent that DFPS has existing resources to implement Texas Family Code §263.1021.

(b) Definitions:

(1) Case Plan: a Case Plan, as defined by 42 U.S.C. 675, is a written document which meets the requirements 42 U.S.C. 675a. Texas has divided the federal requirement of a Case Plan into two separate plans, the Family Service Plan as defined in Texas Family Code §263.101 and the Child's Plan of Service as defined in Texas Family Code §264.128. For the purpose of this Rule, a Child's Plan (also referred to as a Child's Plan of Service) is not a Family Service Plan.

(2) Family Service Plan (also referred to as a "Family Plan of Service," "Family Plan" or "Individual Family Service Plan") is a written plan in which DFPS and a child's parents identify the actions, specific skills, knowledge, steps, and/or responsibilities that are necessary for the parents to achieve the Family Service Plan's goal during this Plan's service period and the assistance to be provided to the parents by the DFPS or other agency toward meeting that goal.

(3) Single Source Continuum Contract/Contractor (SSCC) is an entity, as described in Texas Family Code §264.154, with whom DFPS enters into a contract for the provision of the full continuum of substitute care, case management, and reunification services in a Designated Community Area.

(4) Licensed Provider is an individual who is required by the State of Texas to be licensed to provide the professional service that the parent is receiving and DFPS is reimbursing.

(5) Qualified Provider is an individual who has completed certification or other training programs and has two (2) years of verified full-time experience in the professional service in which they are providing to the parent and DFPS is reimbursing.

(6) Noncontracted Service Provider is one who is not under a current contract with DFPS or SSCC for the service that they are seeking reimbursement. They also cannot be an employee of DFPS or SSCC.

(c) SSCCs must adopt similar requirements relating to the manner in which noncontracted service providers are reimbursed that do not conflict with this Section.

(d) Only the noncontracted service provider may seek reimbursement from DFPS for services and must not have already been paid by the parent or a third party.

(e) To be reimbursed, services may be provided in-person or through an electronic communication platform.

(f) DFPS cannot use state funds to reimburse a noncontracted service provider for Medicaid services to a parent who is a Medicaid beneficiary, as described in Texas Human Resources Code Chapter 32. If the parent has Texas Medicaid, the noncontracted service provider must bill Medicaid and not seek reimbursement through DFPS.

(g) All the following requirements/conditions must be met in order for a noncontracted service provider to be reimbursed:

(1) Must be qualified or licensed provider and comply with the DFPS's guidelines and requirements for reimbursement pursuant to Texas Family Code §263.1021.

(2) If a license is required, the service provider must maintain licensure and the license must remain in good standing while providing services that they are seeking reimbursement.

(3) Services obtained from a service provider selected must be designed to achieve the stated goals of the Family Plan of Service for a child in DFPS conservatorship and the noncontracted service provider must certify whether the parent has satisfactorily completed the required service that is being sought for reimbursement.

(4) DFPS cannot reimburse for services that occur after DFPS is dismissed from the case, or the parental rights have been terminated (earlier of two). If a Family Service is reinstated, then the service provider would have to seek reimbursement though a new claim under the reinstated Family Service Plan.

(5) The noncontracted service provider must be able to receive reimbursement from state or federal funds and not be debarred from receiving these funds.

(6) The noncontracted service provider cannot have had a prior DFPS contract to provide the specific service that they are seeking reimbursement which DFPS terminated for cause.

(7) The noncontracted service provider cannot be related by consanguinity or affinity to the parent receiving services.

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304341
Katharine McLaughlin
Policy Attorney
Department of Family and Protective Services
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 915-1729

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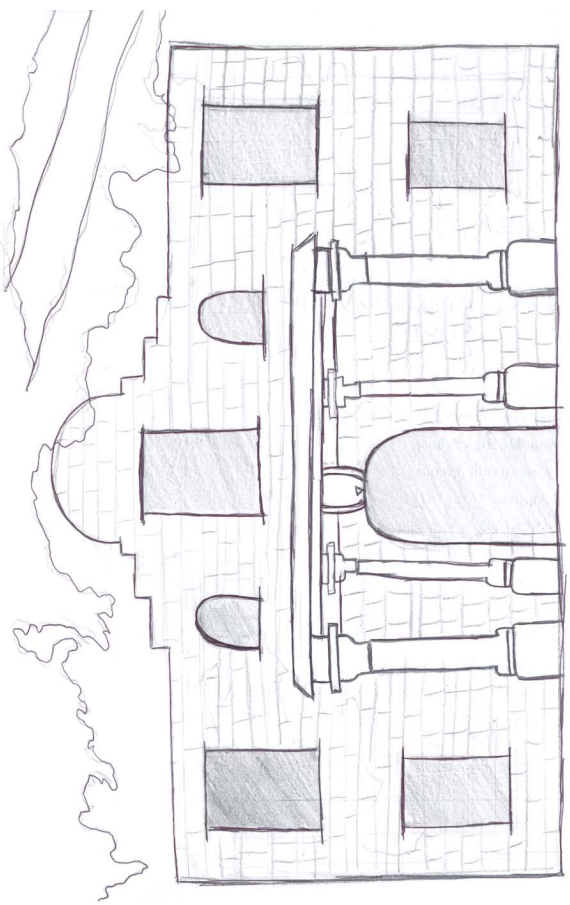

WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER B. DISEASE DETECTION AND RESPONSE

DIVISION 2. CHRONIC WASTING DISEASE - COMPREHENSIVE RULES

31 TAC §65.95

The Texas Parks and Wildlife Department withdraws proposed emergency amendment to §65.95 which appeared in the August 11, 2023, issue of the *Texas Register* (48 TexReg 4337).

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304338

James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: November 20, 2023
For further information, please call: (512) 389-4775

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SUBCHAPTER T. DEER BREEDER PERMITS

31 TAC §65.611

The Texas Parks and Wildlife Department withdraws proposed emergency amendment to §65.611 which appeared in the August 11, 2023, issue of the *Texas Register* (48 TexReg 4337).

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304339
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: November 20, 2023
For further information, please call: (512) 389-4775

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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 354. MEDICAID HEALTH SERVICES

SUBCHAPTER O. ELECTRONIC VISIT VERIFICATION

The Texas Health and Human Services Commission (HHSC) adopts amendments to §354.4001, concerning Purpose and Authority; and §354.4003, concerning Definitions; the repeal of §354.4005, concerning Applicability; §354.4007, concerning EVV System; §354.4009, concerning Requirements for Claims Submission and Approval; §354.4011, concerning Member Rights and Responsibilities; and §354.4013, concerning Additional Requirements; and new §354.4005, concerning Personal Care Services that Require the Use of EVV; §354.4006, concerning Home Health Care Services that Require the Use of EVV; §354.4007, concerning EVV System; §354.4009, concerning EVV Visit Transaction and EVV Claim; §354.4011, concerning Visit Maintenance; §354.4013, concerning HHSC and MCO Compliance Reviews and Enforcement Actions; §354.4015, concerning EVV Training Requirements; §354.4017, concerning Process to Request Approval of a Proposed EVV Proprietary System and Additional Requirements for a PSO; §354.4019, concerning Access to EVV System and EVV Documentation; §354.4021, concerning Additional Requirements; §354.4023, concerning Sanctions; and §354.4025, concerning Administrative Hearing.

Sections 354.4001, 354.4003, 354.4005, 354.4006, 354.4007, 354.4009, 354.4011, 354.4013, 354.4015, 354.4017, 354.4019, 354.4021, 354.4023, and 354.4025; and the repeals of Sections 354.4005, 354.4007, 354.4009, 354.4011, and 354.4013; are adopted without changes to the proposed text as published in the September 8, 2023, issue of the *Texas Register* (48 TexReg 4950). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

In accordance with Section 1903(l) of the Social Security Act (42 U.S.C. §1396b(l)), HHSC requires that electronic visit verification (EVV) be used to document the provision of certain personal care services provided through Medicaid. One purpose of the adopted rules is to ensure that HHSC complies with the requirement in Section 1903(l) that EVV be used to document the provision of Medicaid home health care services. Although Section 1903(l) requires the use of EVV for Medicaid home health services to have begun January 1, 2023, the Centers for Medicare & Medicaid Services (CMS) granted HHSC an extension allowing HHSC to implement this requirement by January 1, 2024.

Another purpose of the adopted rules is to codify in rules current policies and procedures related to EVV including training requirements, visit maintenance requirements, compliance reviews, and the process for HHSC to recognize a health care provider's proprietary EVV system as described in Texas Government Code §531.024172(g).

COMMENTS

The 31-day comment period ended October 9, 2023.

During this period, HHSC received a comment regarding the proposed rules from one commenter representing Grace Personal Assistance Services and Vidanta Personal Assistance Services. A summary of the comment relating to the rules and HHSC's response follows.

Comment: The commenter disagrees with the rules and expressed a concern that HHSC is implementing the rules too soon, making it difficult for providers to comply with the rules.

Response: It is not clear why the commenter disagrees with the rules or why providers will not be able to comply with the rules. The only new requirement in the proposed rules is the use of EVV for the home health care services listed in §354.4006 to comply with Section 1903(l) of the Social Security Act. HHSC notified stakeholders of the expansion of EVV to home health care services effective January 1, 2024, through multiple methods prior to the publication of the proposed EVV rules in the *Texas Register.* HHSC announced the expansion of EVV on the EVV website in October 2022 when CMS granted Texas' request to extend the implementation date. HHSC posted the draft rules for informal comment in January 2023 prior to presentation at the Medical Care Advisory Committee and the HHSC Executive Council meetings in June 2023. In addition, HHSC has a recurring workgroup on the home health care services expansion that has included monthly updates on the status of the rules. Other changes in the proposed rules codify or clarify existing policies and procedures. No changes were made in response to this comment.

1 TAC §§354.4001, 354.4003, 354.4005 - 354.4007, 354.4009, 354.4011, 354.4013, 354.4015, 354.4017, 354.4019, 354.4021, 354.4023, 354.4025

STATUTORY AUTHORITY

The amendments and new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient oper-

ation of the Medicaid program; and Texas Government Code, §531.024172, which provides that the Executive Commissioner of HHSC may adopt rules to implement an electronic visit verification system to electronically verify that personal care services or other services identified by HHSC are provided to Medicaid recipients.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304334
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 1, 2024
Proposal publication date: September 8, 2023
For further information, please call: (737) 867-7813

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1 TAC §§354.4005, 354.4007, 354.4009, 354.4011, 354.4013

STATUTORY AUTHORITY

The repeals are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Human Resources Code, §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program; and Texas Government Code, §531.024172, which provides that the Executive Commissioner of HHSC may adopt rules to implement an electronic visit verification system to electronically verify that personal care services or other services identified by HHSC are provided to Medicaid recipients.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304335
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 1, 2024
Proposal publication date: September 8, 2023
For further information, please call: (737) 867-7813

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TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 122. COMPENSATION PROCEDURE--CLAIMANTS

SUBCHAPTER B. CLAIMS PROCEDURE FOR BENEFICIARIES OF INJURED EMPLOYEES

28 TAC §122.100

The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to 28 TAC §122.100, Claim for Death Benefits. The amendments are adopted with a change to the proposed text published in the September 29, 2023, issue of the *Texas Register* (48 TexReg 5620). DWC held a public hearing on the proposal on October 24, 2023. The text will be republished.

REASONED JUSTIFICATION. Amending §122.100 is necessary to clarify how legal beneficiaries may file claims, consistent with the statute and other rules about notice to insurance carriers, and outline what happens after filing. House Bill (HB) 2314 amended Labor Code §§408.182 and 409.007 to enable eligible beneficiaries to file claims for death benefits with DWC or an insurance carrier, and it imposed recordkeeping and notice requirements on insurance carriers that receive those claims.

Section 122.100 provides requirements for legal beneficiaries to file claims for death benefits. The amendments clarify that they may file a claim with DWC or an insurance carrier. The amendments also cross-reference the associated rule for insurance carriers that receive notices of death or claims for death benefits (Chapter 124, §124.8 of this title, adopted to implement HB 2314), clarify that beneficiaries may provide additional evidence electronically, and include nonsubstantive editorial and formatting changes to conform the section to the agency's current style and to improve the rule's clarity and readability. The amendments are necessary to ease administrative barriers for legal beneficiaries to claim the benefits to which they are entitled, and to ensure that, regardless of the way the claim was initially filed, DWC receives the documentation necessary to process the claim effectively and efficiently.

In response to a comment, DWC has adjusted §122.100(d) from the proposed text to make the processes for collecting additional evidence from potential beneficiaries the same, regardless of filing method, and to streamline the text for clarity. Under §102.5(h) of this title, electronic transmission includes fax, email, electronic data interchange (EDI), or any other similar method. Before HB 2314, all claims had to be filed with DWC, which enabled DWC to guide potential beneficiaries' paper claim submissions to ensure that they were complete. However, now that electronic filing is more advanced, and potential beneficiaries may file their claims with either DWC or the insurance carrier, a simpler, more efficient process for collecting additional evidence that applies regardless of filing method reduces confusion, cost, and regulatory burdens for everyone involved, including potential beneficiaries and insurance carriers.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received three written comments from two commenters on the proposal, and no oral comments. Commenters in support of the proposal were: Texas Mutual Insurance Company. Commenters in support of the proposal with changes were: the Office of Injured Employee Counsel. DWC did not receive comments that were against the proposal.

Comment on §122.100. A commenter stated that they supported the proposed changes in this rule to implement HB 2314.

Agency Response to Comment on §122.100. DWC appreciates the comment and support.

Comment on §122.100(a). A commenter recommended adding a good cause exception to §122.100(a) to allow the filing of claims after the one-year anniversary of the death of the employee for good cause to conform to the requirements of Labor Code §§409.007(b)(2) and 408.108(d-2).

Agency Response to Comment on §122.100(a). DWC appreciates the comment but declines to make the change. An exception to the one-year filing deadline for good cause already exists in §122.100(f)(2), so adding an additional good cause exception to §122.100(a) would be unnecessary and redundant.

Comment on §122.100(d). A commenter recommended changing §122.100(d) to state that a potential beneficiary that files a claim in paper format may file additional evidence at a later time and in paper or electronic format, instead of being required to file additional evidence on paper at the time they file the paper claim.

Agency Response to Comment on §122.100(d). DWC appreciates the comment and has adjusted the rule text to make the processes for collecting additional evidence from potential beneficiaries the same, regardless of filing method, and to streamline the text for clarity.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to 28 TAC §122.100 under Labor Code §§408.182, 409.007, 402.00111, 402.00116, and 402.061.

Labor Code §408.182, as amended by HB 2314, 88th Legislature, Regular Session (2023), provides for the distribution of death benefits to eligible beneficiaries of a deceased employee, when a compensable injury to the employee results in death, and allows an eligible parent to file a claim with DWC or an insurance carrier.

Labor Code §409.007, as amended by HB 2314, 88th Legislature, Regular Session (2023), requires a person to file a claim for death benefits with DWC or an insurance carrier; and provides that, on receiving such a claim, the insurance carrier must, in the form and manner DWC prescribes, create and maintain a record documenting receipt of the claim and provide written notice to DWC that the person filed the claim.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§122.100. Claim for Death Benefits.

(a) Filing. For a legal beneficiary, other than the subsequent injury fund, to receive the benefits available because of the death of an employee that results from a compensable injury, a person must file a written claim for death benefits within one year after the date of the employee's death.

(b) An insurance carrier that receives a claim for death benefits under this section must comply with §124.8 of this title (relating to Receipt, Records, and Notice of Death or Claim for Death Benefits).

(c) Form and information requirements. The claim should be submitted to the division or insurance carrier either on paper or via electronic transmission, in the form, format, and manner prescribed by the division, and should include the following:

(1) the potential beneficiary's name, address, telephone number (if any), Social Security number, and relationship to the deceased employee;

(2) the deceased employee's name, last address, Social Security number (if known), and workers' compensation claim number (if any); and

(3) other information, as follows:

(A) a description of the circumstances and nature of the injury (if known);

(B) the name and location of the employer at the time of the injury;

(C) the date of the compensable injury, and date of death; and

(D) other known legal beneficiaries.

(d) Required documents. A potential beneficiary must file with the division or insurance carrier a copy of the deceased employee's death certificate and any additional documentation or other evidence that establishes that the potential beneficiary is a legal beneficiary of the deceased employee. The required documents or additional evidence may be filed separately either on paper or by electronic transmission, as defined in §102.5(h) of this title.

(e) One claim per person. Each person must file a separate claim for death benefits, unless the claim expressly includes or is made on behalf of another person.

(f) Deadline. Failure to file a claim for death benefits within one year after the date of the employee's death bars the claim of a legal beneficiary, other than the subsequent injury fund, unless:

(1) that legal beneficiary is a minor or otherwise legally incompetent;

(2) except as provided by paragraph (3) of this subsection, good cause exists for failure to file the claim on time; or

(3) for a legal beneficiary who is an eligible parent as defined by §132.6(e) of this title (relating to Eligibility of Other Surviving Dependents and Eligible Parents To Receive Death Benefits), the parent submits proof satisfactory to the commissioner of a compelling reason for the delay in filing the claim for death benefits.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304347

Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: December 11, 2023
Proposal publication date: September 29, 2023
For further information, please call: (512) 804-4703

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CHAPTER 124. INSURANCE CARRIERS: NOTICES, PAYMENTS, AND REPORTING

SUBCHAPTER A. INSURANCE CARRIERS: REQUIRED NOTICES AND MODES OF PAYMENT

28 TAC §124.8

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts new 28 TAC §124.8, Receipt, Records, and Notice of Death or Claim for Death Benefits. The new section is adopted with a change to subsection (c)(1) of the proposed text published in the September 29, 2023, issue of the *Texas Register* (48 TexReg 5622) to eliminate a potential conflict in the timing of the notice. DWC held a public hearing on the proposal on October 24, 2023. The text will be republished.

REASONED JUSTIFICATION. New §124.8 is necessary to implement House Bill (HB) 2314, 88th Legislature, Regular Session (2023). HB 2314 amended Labor Code §§408.182 and 409.007 to enable eligible beneficiaries to file claims for death benefits with DWC or an insurance carrier, and it imposed recordkeeping and notice requirements on insurance carriers that receive those claims.

Section 124.8 cross-references the associated rule for beneficiaries filing claims for death benefits (Chapter 122, §122.100 of this title, with amendments to implement HB 2314) for consistency and ease of use, and clarifies an insurance carrier's obligations, consistent with associated rules for electronic data transactions and other existing rules. It requires an insurance carrier that sends a plain-language notice of potential entitlement to workers' compensation death benefits to a potential beneficiary under existing rules to also send a copy of that notice to DWC.

New §124.8 is necessary to ensure that, if an insurance carrier receives a notice of death or a claim for death benefits, the insurance carrier knows what the requirements for recordkeeping and notice to DWC are. It is also necessary to ensure that procedures for receiving information from claimants, maintaining records, and transmitting information to DWC are as consistent as possible with procedures for other similar situations and with other rules to enhance compliance and reduce confusion. Finally, new §124.8 is necessary to ensure that DWC has the information needed to identify potential claims for death benefits and potential beneficiaries. Having that information is necessary for DWC to ensure that the potential beneficiaries have access to DWC's outreach services, and that insurance carriers have the information they need to process the claims efficiently.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received two written comments on the proposal, and no oral comments. Commenters in support of the proposal with changes were: the Office of Injured Employee Counsel and Texas Mutual Insurance Company. DWC did not receive comments that were against the proposal.

Comments on §124.8. Two commenters requested that DWC clarify when an insurance carrier must send DWC a copy of the plain-language notice that it sends to potential beneficiaries.

Agency Response to Comment on §124.8. DWC appreciates the comments and has clarified the text by deleting the reference that tied sending the plain-language notice to receiving the claim. Section 132.17(d) requires the insurance carrier to send the plain-language notice to the potential beneficiary within seven days of the date the insurance carrier identified or was otherwise made aware of the identity and means of contacting the potential beneficiary. The insurance carrier's obligation is to send DWC a copy of the notice when it sends the notice to the potential beneficiary, so the same seven-day time frame applies.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts new 28 TAC §124.8 under Labor Code §§408.182, 409.007, 402.00111, 402.00116, and 402.061.

Labor Code §408.182, as amended by HB 2314, 88th Legislature, Regular Session (2023), provides for the distribution of death benefits to eligible beneficiaries of a deceased employee, when a compensable injury to the employee results in death, and allows an eligible parent to file a claim with DWC or an insurance carrier.

Labor Code §409.007, as amended by HB 2314, 88th Legislature, Regular Session (2023), requires a person to file a claim for death benefits with DWC or an insurance carrier; and provides that, on receiving such a claim, the insurance carrier must, in the form and manner DWC prescribes, create and maintain a record documenting receipt of the claim and provide written notice to DWC that the person filed the claim.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§124.8. Receipt, Records, and Notice of Death or Claim for Death Benefits.

(a) Definition. In this section, "claim for death benefits" means a claim that is filed under Chapter 122, Subchapter B, §122.100 of this title.

(b) General requirements. An insurance carrier that receives a notice of death in accordance with §132.17 of this title, or a claim for death benefits must comply with all of the requirements in this chapter.

(c) Recordkeeping and notice. An insurance carrier in subsection (b) of this section must:

(1) send the division a copy of the plain-language notice that the insurance carrier must provide to the potential beneficiary under §132.17 of this title.

(2) on receiving a claim for death benefits, create and maintain a record documenting receipt of the claim for death benefits. The

record must include all of the information in the claim for death benefits. The insurance carrier must maintain the record in accordance with Chapter 102, §102.4 of this title.

(3) send the division a copy of a claim for death benefits the insurance carrier receives from the potential beneficiary not later than the seventh day after receiving it and include any other documents and information the insurance carrier received.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304348
Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: December 11, 2023
Proposal publication date: September 29, 2023
For further information, please call: (512) 804-4703

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 13. TEXAS COMMISSION ON FIRE PROTECTION

CHAPTER 463. ADVISORY COMMITTEES, PRACTICE AND PROCEDURES

37 TAC §§463.1, 463.3, 463.5, 463.7, 463.9, 463.11, 463.13, 463.15, 463.17

The Texas Commission on Fire Protection (the Commission) adopts a new chapter, 37 Texas Administrative Code Chapter 463, Advisory Committees, Practice and Procedures, concerning §463.1 Objective, §463.3 General, §463.5 Eligibility, §463.7 Terms, §463.9 Meetings, §463.11 Limitation of Powers, §463.13 Testimony, §463.15 Expulsion, and §463.17 Abolishment Date. The new chapter is adopted without changes to the text as published in the October 20, 2023, issue of the *Texas Register* (48 TexReg 6196). These rules will not be republished.

The new chapter aims to establish rules governing the Commission's advisory committees under Texas Government Code §419.908(f). This new chapter and rules implement a Sunset Commission's recommendation and Senate Bill 709 as passed by the 87th legislature. The chapter enhances transparency by setting out the objectives of the committees, and eligibility for membership, creates staggered terms and term limits, open meeting requirements, limits committees to recommendations only, and addresses public testimony, expulsion, and abolishment. The new chapter ensures each committee continues to achieve the objectives set out by law and rule, and requires the Commission to evaluate the need for the committee and continuation of each committee every four years. The new chapter also implements requirements of Texas Government Code §2110.005, and §2110.008, by setting out by rule the purpose of the committee, the manner the committee will report to the Commission, and the duration of the committees. No other statutes, articles, or codes are affected by these amendments.

No comments were received from the public regarding the adoption of the new rule.

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.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304326
Mike Wisko
Agency Chief
Texas Commission on Fire Protection
Effective date: December 10, 2023
Proposal publication date: October 20, 2023
For further information, please call: (512) 936-3841

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 20. TEXAS WORKFORCE COMMISSION

CHAPTER 810. LONE STAR WORKFORCE OF THE FUTURE FUND

The Texas Workforce Commission (TWC) adopts new Chapter 810, relating to the Lone Star Workforce of the Future Fund, comprising the following subchapters:

Subchapter A. General Provisions Regarding the Lone Star Workforce of the Future Fund, §§810.1 - 810.4

Subchapter B. Advisory Board Composition, Meeting Guidelines, §§810.11 - 810.13

Subchapter C. Program Administration, §§810.21 - 810.28

New §§810.1, 801.3, 810.4, 810.11 - 810.13, and 810.21, and 810.23 - 810.28 are adopted without changes to the proposal, as published in the September 29, 2023, issue of the *Texas Register* (48 TexReg 5645), and, therefore, the adopted rule text will not be published.

New §810.2 and §810.22 are adopted with changes to the proposal, as published in the September 29, 2023, issue of the *Texas Register* (48 TexReg 5645), and, therefore, the adopted rule text will be published.

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

The purpose of implementing new Chapter 810 rules is to establish the Lone Star Workforce of the Future Fund and set forth TWC's procedures for administrating the new grant program.

The 88th Texas Legislature, Regular Session (2023), passed House Bill (HB) 1755, which amended Texas Education Code, Title 3, Subtitle G, by adding Chapter 134A relating to the creation of the Lone Star Workforce of the Future Fund. HB 1755 tasks TWC with the establishment and administration of the Lone Star Workforce of the Future Fund as a dedicated account in the general revenue fund. Furthermore, HB 1755 requires TWC to adopt rules as necessary to administer this chapter.

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS

SUBCHAPTER A. GENERAL PROVISIONS REGARDING THE LONE STAR WORKFORCE OF THE FUTURE FUND

TWC adopts new Subchapter A, General Provisions Regarding the Lone Star Workforce of the Future Fund, as follows:

§810.1. Purpose and Goal

New §810.1(a) states the Lone Star Workforce of the Future Fund's purpose.

New §810.1(b) states the Lone Star Workforce of the Future Fund's goal.

§810.2. Definitions

New §810.2 sets forth the definitions for the Lone Star Workforce of the Future Fund rules.

New §810.2(4) has been changed from the proposal to give "eligible applicant" the same meaning as identified under Texas Education Code §134A.007.

Certain paragraphs in §810.2 have been rearranged in alphabetical order and renumbered accordingly.

§810.3. Uses of the Fund

New §810.3 details what a grant recipient shall use the money for.

§810.4. Waivers

New §810.31 sets forth the Executive's waiver authority.

SUBCHAPTER B. ADVISORY BOARD COMPOSITION, MEETING GUIDELINES

TWC adopts new Subchapter B, Advisory Board Composition, Meeting Guidelines, as follows:

§810.11. Advisory Board Purpose and Composition

New §810.11 provides the purpose of the advisory board and the appointing entities.

§810.12. Meeting Requirements

New §810.12 states the advisory board meeting requirements.

§810.13. Advisory Board Responsibilities

New §810.13 outlines the advisory board responsibilities.

SUBCHAPTER C. PROGRAM ADMINISTRATION

TWC adopts new Subchapter C, Program Administration, as follows:

§810.21. Statement of Purpose

New §810.21 explains the Lone Star Workforce of the Future Fund's purpose.

§810.22. Procedure for Requesting Funding

New §810.22 outlines the procedure in which grant applicants may request funding.

New §810.22 has been changed from the proposal to add that "eligible applicant" has the same meaning as identified under Texas Education Code §134A.007.

§810.23. Procedure for Proposal Evaluation

New §810.23 outlines the evaluation procedure for proposed workforce training projects.

§810.24. Grant Agreement Administration

New §810.24 outlines the administration of the agreement between the grant recipient and TWC.

§810.25. Limitation on Awards

New §810.25 outlines limitations the Commission may impose on awards.

§810.26. Program Objectives

New §810.26 details the Lone Star Workforce of the Future Fund's program objectives.

§810.27. Performance Benchmarks

New §810.27 details performance benchmarks that must be met by grant recipients.

§810.28. Reporting Requirements

New §810.28 details reporting requirements for grant recipients.

TWC hereby certifies that the rules have been reviewed by legal counsel and found to be within TWC's legal authority to adopt.

PART III. PUBLIC COMMENTS

The public comment period closed on October 30, 2023.

TWC received comments from Year Up Austin.

COMMENT: Year Up Austin requested that TWC amend §810.1 to add language stating that public junior colleges, public technical institutes, and nonprofit organizations that administer workforce training programs demonstrate a history of and evidence of strong outcomes.

RESPONSE: The Commission appreciates the comment. However, Texas Education Code §134A.007 establishes grant eligibility. TWC has revised the proposed definition of "eligible applicant" to reflect the statutory requirements. TWC will review each grant application on a case-by-case basis and will ensure that applicants are adequately qualified to meet grant requirements.

COMMENT: Year Up Austin asked if §810.2 needs to include a definition of "nonprofit organization."

RESPONSE: The Commission appreciates the comment; however, the Commission intends on developing and utilizing a definition of a "nonprofit organization" as part of each grant cycle. No changes were made in response to this comment.

COMMENT: Year Up Austin recommended that TWC amend §810.4 so that waivers should be reviewed by the advisory board for input but leave the final decision with the Executive Director.

RESPONSE: As stated in §810.13, the advisory board shall provide advice and recommendations to the Commission on awarding grants under this chapter. The advisory board will not review individual applications. No changes were made in response to this comment.

COMMENT: Year Up Austin asked how the Commission Chair is appointed and by whom.

RESPONSE: The Governor of Texas appoints the Commission Chair. No changes were made in response to this comment.

COMMENT: Year Up Austin asked what the requirements referenced in §810.21 are for nonprofit organizations.

RESPONSE: Regarding which entities are eligible to receive a grant under this program, please refer to Texas Education Code Chapter 134A. No changes were made in response to this comment.

COMMENT: Year Up Austin asked if there is a list of high-growth career fields currently available to view, as referenced under §810.24(b).

RESPONSE: TWC will publish a list of high-growth career fields to this program's dedicated webpage following the formal rule adoption and Commission adoption of such a list. No changes were made in response to this comment.

COMMENT: Year Up Austin recommended that TWC amend §810.24(c)(1) to specify which reports are required by the applicant.

RESPONSE: Reporting requirements may vary from year to year. However, all reporting requirements will be included in the contract between TWC and the grant recipient. No changes were made in response to this comment.

COMMENT: Year Up Austin asked if there were additional limits on the grant amount that can be awarded other than those listed in §810.25.

RESPONSE: Neither the statute nor this proposed rule identifies a financial limit aside from the $15,000 per training program participant. However, the Commission may adopt limitations to the grant amount from time to time. No changes were made in response to this comment.

COMMENT: Year Up Austin recommended that TWC amend the rule by adding the following to the end of §810.26(2): "and promote enhanced educational and career mobility."

RESPONSE: The Commission appreciates the comment; however, this requested change is outside the scope of the proposed rulemaking. No changes were made in response to this comment.

COMMENT: Year Up Austin recommended that TWC amend §810.28(a) to specifically identify where the reporting requirement rules exist.

RESPONSE: Section 810.28 outlines reporting requirements that are defined by Texas Education Code Chapter 134A. However, additional reporting requirements and penalties may be enforced in the contract between TWC and the grant recipient. No changes were made in response to this comment.

SUBCHAPTER A. GENERAL PROVISIONS REGARDING THE LONE STAR WORKFORCE OF THE FUTURE FUND

40 TAC §§810.1 - 810.4

STATUTORY AUTHORITY

The new rules are adopted under the specific authority of House Bill 1755, 88th Texas Legislature, Regular Session (2023), which enacted Texas Education Code §134A.012, which requires TWC to adopt rules necessary for the administration of Texas Education Code Chapter 134A.

The rules are adopted under the general authority of Texas Labor Code §301.0015 and §302.002(d), which provide TWC with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of TWC services and activities.

§810.2. Definitions.

In addition to the definitions contained in §800.2 of this title, the following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Advisory board--the advisory board of education and workforce stakeholders created pursuant to the applicable statute.

(2) Agency--the unit of state government established under Texas Labor Code Chapter 301 that is presided over by the Commission and administered by the Executive Director to operate the integrated workforce development system and administer the unemployment compensation insurance program in this state as established under the Texas Unemployment Compensation Act, Texas Labor Code, Title 4, Subtitle A, as amended. The definition of "Agency" shall apply to all uses of the term in rules contained in this part, unless otherwise defined, relating to the Texas Workforce Commission.

(3) Commission--the body of governance of the Texas Workforce Commission composed of three members appointed by the governor as established under Texas Labor Code §301.002 that includes one representative of labor, one representative of employers, and one representative of the public. The definition of "Commission" shall apply to all uses of the term in rules contained in this part, unless otherwise defined, relating to the Texas Workforce Commission.

(4) Eligible applicant--has the same meaning as identified under Texas Education Code §134A.007.

(5) Executive Director--the Executive Director of the Texas Workforce Commission.

(6) Grant recipient--a recipient of the Lone Star Workforce of the Future Fund.

(7) Public junior college--any junior college certified by the Texas Higher Education Coordinating Board in accordance with Texas Education Code §61.003.

(8) Public technical institute--the Lamar Institute of Technology or the Texas State Technical College System, in accordance with Texas Education Code §61.003.

(9) Statute--Texas Education Code, Chapter 134A, Lone Star Workforce of the Future Fund.

(10) Workforce training program--a program that provides performance-based workforce training that:

(A) leads to skill development and experiences required for employment in high demand occupations;

(B) are developed and provided based on consultation with and input from employers that are hiring in high demand occupations;

(C) create pathways to employment for program participants; and

(D) are delivered through classroom-based or online instruction, work-based experiences, internships or apprenticeships, or through a combination of those methods.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304355
Les Trobman
General Counsel
Texas Workforce Commission
Effective date: December 11, 2023
Proposal publication date: September 29, 2023
For further information, please call: (512) 850-8356

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SUBCHAPTER B. ADVISORY BOARD COMPOSITION, MEETING GUIDELINES

40 TAC §§810.11 - 810.13

The new rules are adopted under the specific authority of House Bill 1755, 88th Texas Legislature, Regular Session (2023), which enacted Texas Education Code §134A.012, which requires TWC to adopt rules necessary for the administration of Texas Education Code Chapter 134A.

The rules are adopted under the general authority of Texas Labor Code §301.0015 and §302.002(d), which provide TWC with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of TWC services and activities.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304356
Les Trobman
General Counsel
Texas Workforce Commission
Effective date: December 11, 2023
Proposal publication date: September 29, 2023
For further information, please call: (512) 850-8356

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SUBCHAPTER C. PROGRAM ADMINISTRATION

40 TAC §§810.21 - 810.28

The new rules are adopted under the specific authority of House Bill 1755, 88th Texas Legislature, Regular Session (2023), which enacted Texas Education Code §134A.012, which requires TWC to adopt rules necessary for the administration of Texas Education Code Chapter 134A.

The rules are adopted under the general authority of Texas Labor Code §301.0015 and §302.002(d), which provide TWC with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of TWC services and activities.

§810.22. Procedure for Requesting Funding.

An eligible applicant, as defined by Texas Education Code §134A.007, shall present to the Executive Director, or designee, an application for funding to acquire grant funds for the provision of workforce training as may be identified by the eligible applicant.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on November 21, 2023.

TRD-202304357
Les Trobman
General Counsel
Texas Workforce Commission
Effective date: December 11, 2023
Proposal publication date: September 29, 2023
For further information, please call: (512) 850-8356

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REVIEW OF AGENCY RULES

This section contains notices of state agency rule review as directed by the Texas Government Code, §2001.039. Included here are proposed rule review notices, which invite public comment to specified rules under review; and adopted rule review notices, which summarize public comment received as part of the review. The complete text of an agency's rule being reviewed is available in the *Texas Administrative Code* on the Texas Secretary of State's website.

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the website and printed copies of these notices may be directed to the *Texas Register* office.

Proposed Rule Reviews

Finance Commission of Texas

Title 7, Part 1

On behalf of the Finance Commission of Texas (commission), the Office of Consumer Credit Commissioner files this notice of intention to review and consider for readoption, revision, or repeal, Texas Administrative Code, Title 7, Part 1, Chapter 1, concerning Consumer Credit Regulation.

This rule review will be conducted pursuant to Texas Government Code, §2001.039. The commission will accept written comments received on or before the 30th day after the date this notice is published in the *Texas Register* as to whether the reasons for adopting these rules continue to exist.

The Office of Consumer Credit Commissioner, which administers these rules, believes that the reasons for adopting the rules contained in this chapter continue to exist. Any questions or written comments pertaining to this notice of intention to review should be directed to Matthew Nance, General Counsel, Office of Consumer Credit Commissioner, 2601 North Lamar Boulevard, Austin, Texas 78705, or by email to rule.comments@occc.texas.gov. Any proposed changes to the rules as a result of the review will be published in the Proposed Rules Section of the *Texas Register* and will be open for an additional public comment period prior to final adoption or repeal by the commission.

TRD-202304383
Matthew Nance
General Counsel
Finance Commission of Texas
Filed: November 29, 2023

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Office of Consumer Credit Commissioner

Title 7, Part 5

On behalf of the Finance Commission of Texas (commission), the Office of Consumer Credit Commissioner files this notice of intention to review and consider for readoption, revision, or repeal, Texas Administrative Code, Title 7, Part 5, Chapter 82, concerning Administration.

This rule review will be conducted pursuant to Texas Government Code, §2001.039. The commission will accept written comments received on or before the 30th day after the date this notice is published in the *Texas Register* as to whether the reasons for adopting these rules continue to exist.

The Office of Consumer Credit Commissioner, which administers these rules, believes that the reasons for adopting the rules contained in this chapter continue to exist. Any questions or written comments pertaining to this notice of intention to review should be directed to Matthew Nance, General Counsel, Office of Consumer Credit Commissioner, 2601 North Lamar Boulevard, Austin, Texas 78705, or by email to rule.comments@occc.texas.gov. Any proposed changes to the rules as a result of the review will be published in the Proposed Rules Section of the *Texas Register* and will be open for an additional public comment period prior to final adoption or repeal by the commission.

TRD-202304384
Matthew Nance
General Counsel
Office of Consumer Credit Commissioner
Filed: November 29, 2023

♦ ♦ ♦

Records Management Interagency Coordinating Council

Title 13, Part 4

The Records Management Interagency Coordinating Council (RMICC) files this notice of its intent to review Texas Administrative Code, Title 13, Part 4, Chapter 50, Council Procedures, consisting of §50.1, Purpose; §50.3, Officers; §50.5, Meetings; §50.7, Committees; §50.9, Staff; and §50.11, Rules; in accordance with Texas Government Code, §2001.039.

The review will include, at a minimum, an assessment of whether the reasons for initially adopting the rules continue to exist.

The Texas State Library and Archives Commission will accept comments regarding the review on behalf of RMICC. The comment period will last for 30 days following the publication of this notice in the *Texas Register.* Comments regarding this review may be submitted to Sarah Swanson, General Counsel, Texas State Library and Archives Commission, 1201 Brazos Street, P.O. Box 12927, Austin, Texas 78711-2927 or to *rules@tsl.texas.gov* with the subject line "Rule Review."

TRD-202304359
April Norris
Records Management Interagency Coordinating Council Chair
Records Management Interagency Coordinating Council
Filed: November 21, 2023

♦ ♦ ♦

Adopted Rule Reviews

Department of State Health Services

Title 25, Part 1

The Texas Health and Human Services Commission (HHSC), on behalf of Texas Department of State Health Services (DSHS), adopts the review of the chapter below in Title 25, Part 1, of the Texas Administrative Code:

Chapter 49, Oral Health Improvement Program

Notice of the review of this chapter was published in the October 6, 2023, issue of the *Texas Register* (48 TexReg 5827). HHSC and DSHS received three comments concerning this chapter. A summary of comments and DSHS' responses follows.

Comment: The Texas Dental Association (TDA) indicated that they strongly support the readoption of the rules governing the Oral Health Improvement Program (OHIP).

Response: DSHS intends to readopt 25 TAC Chapter 49, Oral Health Improvement Program.

Comment: TDA asks that the program always be headed by a Texas licensed dentist as it is now.

Response: The current rules require that the OHIP director is a Texas licensed dentist.

Comment: TDA states that DSHS should reinstate state funding will help make certain that each individual dental health region is fully staffed as well as expand the OHIP to include low-cost or free direct care dental services to Texans that rely on the dental safety net.

Response: State funding for OHIP is determined by the Texas Legislature.

HHSC and DSHS have reviewed Chapter 49 in accordance with §2001.039 of the Texas Government Code, which requires state agencies to assess, every four years, whether the initial reasons for adopting a rule continue to exist. The agencies determined that the original reasons for adopting all rules in the chapter continue to exist and readopts Chapter 49. Any amendments or repeals to Chapter 49 identified by HHSC and DSHS in the rule review will be proposed in a future issue of the *Texas Register*.

This concludes HHSC's and DSHS' review of 25 TAC Chapter 49 as required by the Texas Government Code, §2001.039.

TRD-202304374
Jessica Miller
Director, Rules Coordination Office
Department of State Health Services
Filed: November 28, 2023

♦ ♦ ♦

The Texas Health and Human Services Commission (HHSC), on behalf of the Texas Department of State Health Services (DSHS), adopts the review of the chapter below in Title 25, Part 1, of the Texas Administrative Code:

Chapter 97, Communicable Diseases

Subchapter A - Control of Communicable Diseases

Subchapter B - Immunization Requirements in Texas Elementary and Secondary Schools and Institutions of Higher Education

Subchapter C - Consent for Immunization

Subchapter D - Statewide Immunization of Children in Certain Facilities and by Hospitals, Physicians, and Other Health Care Providers

Subchapter E - Provision of Anti-Rabies Biologicals

Subchapter F - Sexually Transmitted Diseases Including Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV)

Subchapter G - Vaccination Stamps

Subchapter H - Tuberculosis Screening for Jails and Other Correctional Facilities

Subchapter I - Immunization Requirements for Residents of Texas Nursing Homes

Subchapter K - Respiratory Syncytial Virus

Notice of the review of this chapter was published in the October 13, 2023, issue of the *Texas Register* (48 TexReg 5987). HHSC and DSHS received no comments concerning this chapter.

HHSC and DSHS has reviewed Chapter 97 in accordance with §2001.039 of the Texas Government Code, which requires state agencies to assess, every four years, whether the initial reasons for adopting a rule continue to exist. The agencies determined that the original reasons for adopting all rules in the chapter continue to exist and readopts Chapter 97. Any amendments or repeals to Chapter 97 identified by HHSC and DSHS in the rule review will be proposed in a future issue of the *Texas Register*.

This concludes HHSC's and DSHS' review of 25 TAC Chapter 97 as required by the Texas Government Code, §2001.039.

TRD-202304380
Jessica Miller
Director, Rules Coordination Office
Department of State Health Services
Filed: November 28, 2023

♦ ♦ ♦

Health and Human Services Commission

Title 26, Part 1

The Health and Human Services Commission (HHSC) adopts the review of the chapter below in Title 26, Part 1, of the Texas Administrative Code (TAC):

Chapter 303, Preadmission Screening and Resident Review (PASRR)

Subchapter A General Provisions

Subchapter B PASRR Screening and Evaluation Process

Subchapter C Responsibilities

Subchapter D Vendor Payment

Subchapter E Habilitation Coordination

Subchapter F Habilitative Service Planning for A Designated Resident

Subchapter G Transition Planning

Subchapter H Compliance Review

Subchapter I MI Specialized Services

Notice of the review of this chapter was published in the October 6, 2023, issue of the *Texas Register* (48 TexReg 5828). HHSC received no comments concerning this chapter.

HHSC has reviewed Chapter 303 in accordance with §2001.039 of the Texas Government Code, which requires state agencies to assess, every four years, whether the initial reasons for adopting a rule continue to exist. The agency determined that the original reasons for adopting all rules in the chapter continue to exist and readopts Chapter 303. Any

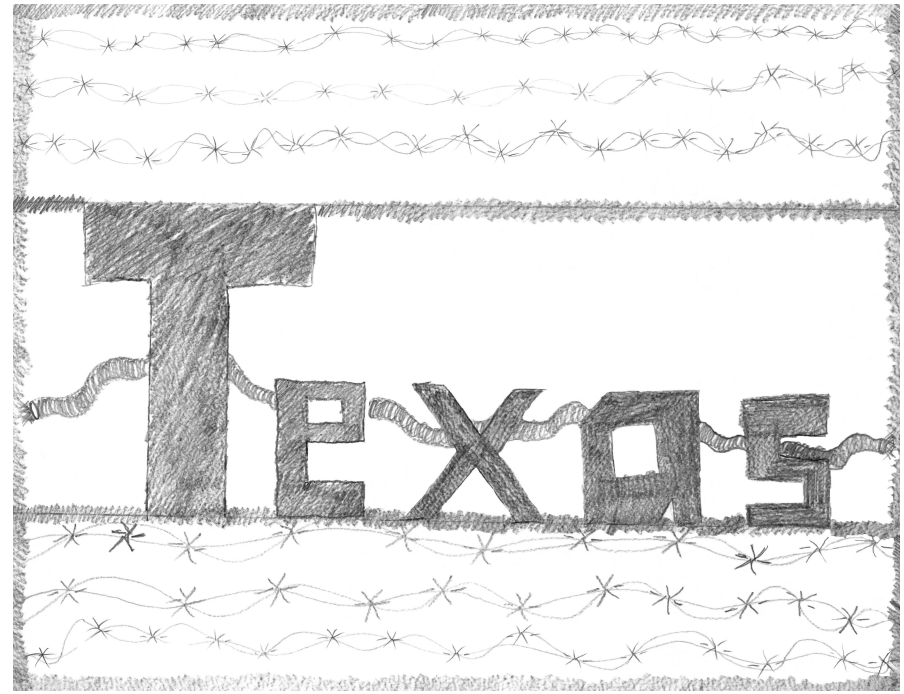
amendments or repeals to Chapter 303 identified by HHSC in the rule review will be proposed in a future issue of the *Texas Register*.

This concludes HHSC's review of 26 TAC Chapter 303 as required by the Government Code, §2001.039.

TRD-202304379

Jessica Miller
Director, Rules Coordination Office
Health and Human Services Commission
Filed: November 28, 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: 28 TAC §3.3705(f)(1)

Your rights with a preferred provider (PPO) health plan

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors and facilities to treat its members at discounted rates. These providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

You can get a directory of doctors, facilities, and other health care providers that are in your plan's network.

You can get the directory online at [enter website] or by calling [enter phone number].

If you used your health plan's directory to pick an in-network doctor or facility and the doctor or facility turns out to be out-of-network, you might not have to pay the extra cost that out-of-network doctors and facilities charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network (called "out-of-network"), you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor or facility, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

Figure: 28 TAC §3.3705(f)(2)

Your rights with an exclusive provider (EPO) health plan

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors and facilities to treat its members at discounted rates. These providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

There are exceptions for emergencies, when you didn't pick the doctor, and for air ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors

You can get a directory of doctors and facilities that are in your plan's network.

You can get the directory online at [enter website] or by calling [enter phone number].

If you used your health plan's directory to pick an in-network doctor or facility and the doctor or facility turns out to be out-of-network, you might not have to pay the extra cost that out-of-network doctors and facilities charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas Department of Agriculture

Notice of Public Hearing on Proposed Amendments to 4 Texas Administration Code §7.30, Concerning Classification of Pesticides

Date of Public Hearing:

December 27, 2023

Time of Public Hearing:

Hearing Start time: 9:00 a.m.

Public Comment Sign Up ends: 11:00 a.m.

Hearing End time: 11:00 a.m. or until all public comment concludes (whichever is earlier); provided, however, the hearing will conclude no later than 12:00 p.m.

Location:

Texas Capitol Extension Auditorium

1100 Congress Ave., Austin, Texas 78701

Capitol Extension, Room E1.004

Hearing:

The Texas Department of Agriculture (Department) will hold a public hearing on December 27, 2023 from 9:00 a.m. to 12:00 p.m. to receive public comment on the Department's proposed amendments to 4 Texas Administration Code §7.30, concerning Classification of Pesticides. The proposed amendments add a new subsection (d) to §7.30 to classify pesticide products containing the active ingredient warfarin as "state-limited-use" pesticides when used as a feral hog toxicant and to establish related licensure requirements. The proposed amendments were published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 6983). The proposed amendments can also be accessed through the Department's Pesticide Program webpage at https://www.texasagriculture.gov/Regulatory-Programs/Pesticides.

The hearing is being held in accordance with Section 76.003(a) of the Texas Agriculture Code (Code), which requires the Department to conduct a public hearing on the designation of a pesticide as a state-limited-pesticide, and Section 76.104 of the Code, which requires the Department to conduct a public hearing on proposed rules related to the use and application of pesticides.

This public hearing will be at the Texas Capitol Extension Auditorium, 1100 Congress Ave., Austin, Texas 78701, Capitol Extension, Room E1.004. There will be no option to participate virtually in this hearing.

Agenda:

1. Call to Order

2. Public hearing to receive comments from interested persons concerning proposed amendments to 4 Texas Administration Code §7.30, concerning Classification of Pesticides. Any interested person may appear and offer comments or statements; however, questioning commenters will be reserved exclusively for Department staff as may be necessary to ensure a complete record. While any person with pertinent comments or statements will be granted an opportunity to present them during the course of the hearing, the Department reserves the right to restrict statements in terms of time or repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views or similar comments through a representative member when possible.

3. Adjourn

Comments:

Public Comment or Testimony. The Department welcomes public comments pertaining to the proposed rule amendments. Members of the public who would like to provide public comment may choose from the following options:

Oral Comments. Each public comment is limited to no more than five minutes in length. The Department may extend this time period if it considers appropriate to do so under the circumstances. Speakers must state their name and on whose behalf they are speaking (if anyone).

Written Comments. Written comments regarding the proposed rule amendments may also be submitted instead of, or in addition to, oral comments until January 1, 2024. Written comments may be sent to Philip Wright, Texas Department of Agriculture, at P.O. Box 12847, Austin, Texas 78711, or Philip.Wright@TexasAgriculture.gov with a subject line reading **"Public Comment - State-Limited-Use Pesticide; Warfarin."**

Auxiliary Aids or Services for Persons with a Disability: If you would like to attend the meeting and require auxiliary aids or services, please notify the Texas Department of Agriculture at least 72 hours before the meeting so that appropriate arrangements can be made. Requests may be made by telephone to (512) 475-0044 or by email to Jim.Reaves@TexasAgriculture.gov.

For more information regarding this public hearing, please contact Jim Reaves, Coordinator for Intergovernmental Affairs, Texas Department of Agriculture, at P.O. Box 12847, Austin, Texas 78711, (512) 475-0044 or Jim.Reaves@TexasAgriculture.gov.

TRD-202304373
Susan Maldonado
General Counsel
Texas Department of Agriculture
Filed: November 27, 2023

♦ ♦ ♦

Office of the Attorney General

Request for Applications (RFA) for the Sexual Assault Prevention and Crisis Services (SAPCS)-State: Advocacy Enhancement and Counseling Waitlist Reduction

The Office of the Attorney General (OAG) is soliciting applications from programs with an active SAPCS-State grant contract that provide services to victims of sexual assault.

Applicable Funding Source: The source of funding is through a biennial appropriation by the Texas Legislature. All funding is contingent

upon an appropriation to the OAG by the Texas Legislature. The OAG makes no commitment that an application, once submitted, or a grant, once funded, will receive subsequent funding.

Eligibility Requirements:

Eligible Applicants: Applicant must be a current FY 2024 SAPCS-State grantee. A current SAPCS-State grantee is a Sexual Assault Program with an active (September 1, 2023 - August 31, 2024) SAPCS-State grant contract.

Eligibility: The OAG will initially screen each application for eligibility. Applications will be deemed ineligible if the application is submitted by an ineligible Applicant; the application is not submitted in the manner and form required by the Application Kit; the application is submitted after the deadline established in the Application Kit; or the application does not meet other requirements as stated in the RFA and the Application Kit.

How to Obtain Application Kit: The OAG will post the Application Kit on the OAG's website at https://www.texasattorneygeneral.gov/divisions/grants. Updates and other helpful reminders about the application process will also be posted at this location. Potential Applicants are encouraged to refer to the site regularly.

Deadlines and Filing Instructions for the Grant Application:

Create an On-Line Account: Creating an on-line account in the Grant Offering and Application Lifecycle System (GOALS) is required to apply for a grant. If an on-line account is not created, the Applicant will be unable to apply for funding. To create an on-line account, the Applicant must email the point of contact information to Grants@oag.texas.gov with the following information:

First Name

Last Name

Email Address (*It is highly recommended to use a generic organization email address if available*)

Organization Legal Name

Application Deadline: The Applicant must submit its application, including all required attachments, to the OAG by the deadline and the manner and form established in the Application Kit.

Filing Instructions: Strict compliance with the submission instructions, as provided in the Application Kit, is required. The OAG will **not** consider an Application if it is not submitted by the due date. The OAG will **not** consider an Application if it is not in the manner and form as stated in the Application Kit.

Minimum and Maximum Amounts of Funding Available: The minimum amount of funding for all programs is $60,000 per fiscal year. The maximum amount of funding for all programs is $100,000 per fiscal year.

Minimum and maximum amounts of funding are subject to change as stated in the Application Kit. The OAG is not obligated to fund a grant at the amount requested.

Start Date and Length of Grant Contract Period: The grant contract period (term) is up to two years from January 1, 2024 through August 31, 2025, subject to and contingent on funding and/or approval by the OAG.

No Match Requirements: There are no match requirements.

Award Criteria: The OAG will make funding decisions that support the efficient and effective use of public funds. Scoring components will include, but are not limited to, information provided by the Applicant on the proposed project activities and budget. Funding decisions will be determined using a competitive allocation method.

Grant Purpose Area: All grant projects must address one or more of the purpose areas as stated in the Application Kit.

Prohibitions on Use of Grant Funds: OAG grant funds may not be used to support or pay the costs of lobbying; indirect costs; fees to administer a subcontract; any portion of the salary or any other compensation for an elected government official; the purchase of food and beverages except as allowed under Texas State Travel Guidelines; the purchase or lease of vehicles; the purchase of promotional items or recreational activities; costs of travel that are unrelated to the direct delivery of services that support the OAG grant-funded program; the costs for consultants or vendors who participate directly in writing a grant application; or for any unallowable costs set forth in applicable state or federal law, rules, regulations, guidelines, policies, procedures or cost principles. Grant funds may not be used to purchase any other products or services the OAG identifies as inappropriate or unallowable within this RFA or the Application Kit.

OAG Contact Information: If additional information is needed, contact the Grants Administration Division at Grants@oag.texas.gov, or (512) 936-0792.

TRD-202304378
Austin Kinghorn
General Counsel
Office of the Attorney General
Filed: November 28, 2023

♦ ♦ ♦

Texas Water Code Settlement Notice

The State of Texas gives notice of the following proposed resolution of an environmental enforcement action under the Texas Water Code. Before the State may enter into a voluntary settlement agreement, pursuant to Section 7.110 of the Texas Water Code, the State shall permit the public to comment in writing. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreement if the comments disclose facts or considerations indicating that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the law.

Case Title and Court: *State of Texas v. Angelina County Water Control and Improvement District No. 4;* Cause No. D-1-GN-18-002078; in the 459th Judicial District, Travis County, Texas.

Background: Angelina County Water Control and Improvement District No. 4 (the "District") was created by the Texas Legislature to be a governmental taxing authority that could install a sewer system for the Wildwood community in the southern portion of Angelina County. Pursuant to Chapter 49 of the Texas Water Code and Title 30, Chapter 293, of the Texas Administrative Code, the District was obligated to comply with certain financial reporting requirements, including the submission of annual audit reports, annual financial reports, annual financial dormancy affidavits, and/or annual filing affidavits (collectively, "Annual Financial Filings") to the Texas Commission on Environmental Quality ("TCEQ") for each fiscal year. The District failed to submit proper Annual Financial Filings for fiscal years 2012, 2013, 2014, 2015, 2016, and 2017. The State initiated suit on behalf of the TCEQ to address the District's violations of Texas law regarding the financial reporting of water districts.

Proposed Settlement: The parties propose an Agreed Final Judgment and Permanent Injunction that orders the District to submit proper Annual Financial Filings for fiscal years 2021, 2022, and every year following the effective date of the settlement. The proposed judgment

also awards the State against the District $3,000.00 in attorney's fees and costs.

For a complete description of the proposed settlement, the agreed judgment should be reviewed in its entirety. Requests for copies of the proposed judgment and settlement, and written comments on the same, should be directed to Wesley S. Williams, Assistant Attorney General, Office of the Attorney General of Texas, P.O. Box 12548, MC 066, Austin, Texas 78711-2548; (512) 463-2012; facsimile (512) 320-0911; email Wesley.Williams@oag.texas.gov. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-202304372
Austin Kinghorn
General Counsel
Office of the Attorney General
Filed: November 27, 2023

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Comptroller of Public Accounts

Certification of the Average Closing Price of Gas and Oil - October 2023

The Comptroller of Public Accounts, administering agency for the collection of the Oil Production Tax, has determined, as required by Tax Code, §202.058, that the average taxable price of oil for reporting period October 2023 is $52.01 per barrel for the three-month period beginning on July 1, 2023, and ending September 30, 2023. Therefore, pursuant to Tax Code, §202.058, oil produced during the month of October 2023, from a qualified low-producing oil lease, is not eligible for credit on the oil production tax imposed by Tax Code, Chapter 202.

The Comptroller of Public Accounts, administering agency for the collection of the Natural Gas Production Tax, has determined, as required by Tax Code, §201.059, that the average taxable price of gas for reporting period October 2023 is $1.28 per mcf for the three-month period beginning on July 1, 2023, and ending September 30, 2023. Therefore, pursuant to Tax Code, §201.059, gas produced during the month of October 2023, from a qualified low-producing well, is eligible for a 100% credit on the natural gas production tax imposed by Tax Code, Chapter 201.

The Comptroller of Public Accounts, administering agency for the collection of the Franchise Tax, has determined, as required by Tax Code, §171.1011(s), that the average closing price of West Texas Intermediate crude oil for the month of October 2023 is $85.47 per barrel. Therefore, pursuant to Tax Code, §171.1011(r), a taxable entity shall not exclude total revenue received from oil produced during the month of October 2023, from a qualified low-producing oil well.

The Comptroller of Public Accounts, administering agency for the collection of the Franchise Tax, has determined, as required by Tax Code, §171.1011(s), that the average closing price of gas for the month of October 2023 is $3.15 per MMBtu. Therefore, pursuant to Tax Code, §171.1011(r), a taxable entity shall exclude total revenue received from gas produced during the month of October 2023, from a qualified low-producing gas well.

Inquiries should be submitted to Jenny Burleson, Director, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711-3528.

This agency hereby certifies that legal counsel has reviewed this notice and found it to be within the agency's authority to publish.

Issued in Austin, Texas, on November 29, 2023.

TRD-202304387
Jenny Burleson
Director, Tax Policy
Comptroller of Public Accounts
Filed: November 29, 2023

♦ ♦ ♦

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, 303.009, and 304.003, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/27/23 - 12/03/23 is 18.00% for consumer[1] credit.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 11/27/23 - 12/03/23 is 18.00% for commercial[2] credit.

The postjudgment interest rate as prescribed by §304.003 for the period of 12/01/23 - 12/31/23 is 8.50%.

[1] Credit for personal, family, or household use.

[2] Credit for business, commercial, investment, or other similar purpose.

TRD-202304360
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: November 27, 2023

♦ ♦ ♦

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §303.003, and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/04/23 - 12/10/23 is 18.00% for consumer[1] credit.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/04/23 - 12/10/23 is 18.00% for commercial[2] credit.

[1] Credit for personal, family, or household use.

[2] Credit for business, commercial, investment, or other similar purpose.

TRD-202304385
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: November 29, 2023

♦ ♦ ♦

Texas Education Agency

Request for Applications Concerning the 2024-2025 Charter School Program (Subchapter C) Grant

Filing Authority. The availability of grant funds under Request for Applications (RFA) #701-24-117 is authorized by Public Law 114-95, Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act of 2015, Title IV, Part C, Expanding Opportunity Through Quality Charter Schools; Texas Education Code (TEC), Chapter 12; and 19 Texas Administrative Code Chapter 100, Subchapter AA.

Eligible Applicants. Texas Education Agency (TEA) is requesting applications under RFA #701-24-117 from eligible applicants, which include open-enrollment charter schools that meet the federal definition of a charter school, have never received funds under this grant program, and meet the following qualifications: a campus charter school authorized by the local board of trustees pursuant to TEC, Chapter 12, Subchapter C, on or before December 15, 2023, as a new charter school, or as a charter school that is designed to replicate a new charter school campus, based on the educational model of an existing high-quality charter school, and that submits all required documentation as stated in this RFA. A campus charter school must apply through its public school district, and the application must be signed by the district's superintendent or the appropriate designee.

Important: Any charter school that does not open prior to Wednesday, September 3, 2025, after having been awarded grant funds may be required to forfeit any remaining grant funds and may be required to reimburse any expended amounts to TEA.

Description. The purpose of the Texas Quality Charter Schools Program (Subchapter C) Grant is to support the growth of high-quality district-authorized campus charter schools in Texas, especially those focused on improving academic outcomes for educationally disadvantaged students. This program will provide financial assistance for the planning, program design, and initial implementation of the campus charter school. By administering the 2024-2025 Charter School Program (Subchapter C) Grant, eligible applicants will be supported in opening and preparing for the operation of new district-authorized campus charter schools and replicated high-quality schools.

Dates of Project. The 2024-2025 Charter School Program (Subchapter C) Grant will be implemented during the 2024-2025 and 2025-2026 school years. Applicants should plan for a starting date of no earlier than April 1, 2024, and an ending date of no later than September 30, 2025.

Project Amount. Approximately $9 million is available for funding the 2024-2025 Charter School Program (Subchapter C) Grant. It is anticipated that approximately 10 grants will be awarded up to $900,000. This project is funded 100% with federal funds.

Selection Criteria. Applications will be selected based on the ability of each applicant to carry out all requirements contained in the RFA. Reviewers will evaluate applications based on the overall quality and validity of the proposed grant programs and the extent to which the applications address the primary objectives and intent of the project. Applications must address each requirement and minimum scoring criteria as specified in the RFA to be considered for funding. TEA reserves the right to select from the highest-ranking applications those that address all requirements in the RFA.

TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TEA to pay any costs before an application is approved. The issuance of this RFA does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Applicants' Conference. A webinar will be held on Tuesday, December 19, 2023, at 9:30 a.m. (Central Time). Register for the webinar at https://zoom.us/meeting/register/tJAsd-yuqz8iGdY1dOJLUKcuN0zCv6yN9f82. Questions relevant to the RFA may be emailed to Charlotte Nicklebur at CharterSchools@tea.texas.gov prior to 12:00 p.m. (Central Time) on Monday, December 18, 2023. These questions, along with other information, will be addressed during the webinar. The applicants' conference webinar will be open to all potential applicants and will provide general and clarifying information about the grant program and the RFA.

Requesting the Application. The complete RFA will be posted on the TEA Grant Opportunities web page at https://tea4avalonzo.tea.state.tx.us/GrantOpportunities/forms/GrantProgramSearch.aspx for viewing and downloading. In the "Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view and download all documents that pertain to this RFA.

Further Information. In order to make sure that no prospective applicant obtains a competitive advantage because of acquisition of information unknown to other prospective applicants, any and all questions must be submitted in writing to CharterSchools@tea.texas.gov, the TEA email address identified in the Program Guidelines of the RFA, no later than January 10, 2024. All questions and the written answers thereto will be posted on the TEA Grant Opportunities web page in the format of Frequently Asked Questions (FAQs) by January 12, 2024. In the "Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view all documents that pertain to this RFA.

Deadline for Receipt of Applications. Applications must be submitted to competitivegrants@tea.texas.gov. Applications must be received no later than 11:59 p.m. (Central Time), January 22, 2024, to be considered eligible for funding.

Issued in Austin, Texas, on November 29, 2023.

TRD-202304388
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Filed: November 29, 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 **January 12, 2024.** TWC, §7.075, also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be received by 5:00 p.m. on **January 12, 2024.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission's enforce-

ment coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075, provides that comments on the AOs shall be submitted to the commission in writing.

(1) COMPANY: Angelina and Neches River Authority; DOCKET NUMBER: 2023-0586-PWS-E; IDENTIFIER: RN101459758; LOCATION: Diboll, Angelina County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.115(f)(1) and Texas Health and Safety Code, §341.0315(c), by failing to comply with the maximum contaminant level of 0.080 milligrams per liter for total trihalomethanes, based on the locational running annual average; PENALTY: $1,650; ENFORCEMENT COORDINATOR: Christiana McCrimmon, (512) 239-2811; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(2) COMPANY: CEMEX Construction Materials South, LLC; DOCKET NUMBER: 2021-0740-EAQ-E; IDENTIFIER: RN102437274; LOCATION: New Braunfels, Comal County; TYPE OF FACILITY: aggregate production operation; RULES VIOLATED: 30 TAC §213.4(a)(1) and §213.5(a)(4), by failing to obtain approval of an Edwards Aquifer Protection Plan for an aboveground storage tank facility prior to commencing a regulated activity over the Edwards Aquifer Recharge and Transition Zones; PENALTY: $7,500; ENFORCEMENT COORDINATOR: Mark Gamble, (512) 239-2587; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 492-3096.

(3) COMPANY: Centex Materials LLC; DOCKET NUMBER: 2021-0669-MLM-E; IDENTIFIER: RN102190592; LOCATION: Buda, Hays County; TYPE OF FACILITY: aggregate production operation; RULES VIOLATED: 30 TAC §213.4(j)(6) and Edwards Aquifer Protection Plan Number 11001536, by failing to obtain approval of a modification to an approved aboveground storage tank system facility plan prior to commencing a regulated activity over the Edwards Aquifer Recharge Zone; 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) General Permit Number TXR05DB38, Part III, Section B.5, by failing to conduct annual comprehensive compliance evaluations at the site and assess the effectiveness of the stormwater pollution prevention plan; 30 TAC §305.125(1) and TPDES General Permit Number TXR05DB38, Part III, Section E.6(a)(1) and (2), by failing to conduct annual effluent limitations monitoring by December 31st each year and submit the report to the TCEQ by March 31st of the following year; and 30 TAC §305.125(1) and TPDES General Permit Number TXR05DB38, Part IV, Section A.1 and B, by failing to conduct benchmark monitoring for discharges from regulated industrial activities once every six months; PENALTY: $23,580; ENFORCEMENT COORDINATOR: Taylor Williamson, (512) 239-2097; REGIONAL OFFICE: P.O. Box 13087, Austin, Texas 78711-3087, (512) 339-2929.

(4) COMPANY: City of Paducah; DOCKET NUMBER: 2022-0385-PWS-E; IDENTIFIER: RN101385029; LOCATION: Paducah, Cottle County; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §290.41(c)(1)(D), by failing to ensure that livestock in pastures are not allowed within 50 feet of the facility's Well Number 13; 30 TAC §290.42(l), by failing to compile and maintain a thorough and up-to-date plant operations manual for operator review and reference; 30 TAC §290.43(c)(4), by failing to provide all ground storage tanks (GSTs) with a liquid level indicator; 30 TAC §290.43(e), by failing to provide all potable water storage tanks and pressure maintenance facilities with a lockable building that is designed to prevent intruder access or enclosed by an intruder-resistant fence with lockable gates; 30 TAC §290.44(d) and §290.46(r), by failing to provide a minimum pressure of 35 pounds per square inch (psi) throughout the distribution system under normal operating conditions and 20 psi during emergencies such as firefighting; 30 TAC §290.44(h)(1), by failing to prevent a water connection from the public drinking water supply system to any residence or establishment where an actual or potential contamination hazard exists without ensuring the public water facilities are protected from contamination; 30 TAC §290.44(h)(1)(A), by failing to ensure additional protection was provided at all residences or establishments where an actual or potential contamination hazard exists in the form of an air gap or backflow prevention assembly (BPA), as identified in 30 TAC §290.44(h)(4) and §290.47(f) , by failing to have all BPAs tested upon installation and on an annual basis by a recognized backflow assembly tester and certified that they are operating within specifications; 30 TAC §290.46(d)(2)(A) and §290.110(b)(4) and Texas Health and Safety Code, §341.0315(c), by failing to maintain a disinfectant residual of at least 0.2 milligrams per liter of free chlorine throughout the distribution system at all times; 30 TAC §290.46(l), by failing to flush all dead-end mains at monthly intervals; 30 TAC §290.46(m)(1)(A), by failing to inspect the facility's three GSTs annually; 30 TAC §290.46(m)(4), by failing to maintain all water treatment units, storage and pressure maintenance facilities, distribution system lines, and related appurtenances in a watertight condition and free of excessive solids; 30 TAC §290.46(n)(2), by failing to make available an accurate and up-to-date map of the distribution system so that valves and mains can be easily located during emergencies; 30 TAC §290.46(s)(2)(C)(i), by failing to verify the accuracy of the manual disinfectant residual analyzer at least once every 90 days using chlorine solutions of known concentrations; and 30 TAC §290.46(u), by failing to plug an abandoned public water supply well with cement in accordance with 16 TAC Chapter 76 or submit test results proving that the well is in a non-deteriorated condition; PENALTY: $50,015; ENFORCEMENT COORDINATOR: Ryan Byer, (512) 239-2571; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(5) COMPANY: CLEBURNE STORAGE LLC; DOCKET NUMBER: 2023-1095-WQ-E; IDENTIFIER: RN111688131; LOCATION: Cleburne, Johnson County; TYPE OF FACILITY: operator; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain authorization to discharge stormwater associated with construction activities; PENALTY: $875; ENFORCEMENT COORDINATOR: Shane Glantz, (325) 698-6124; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(6) COMPANY: Dorothea Edmonds dba James Mini Mart Exxon; DOCKET NUMBER: 2022-1554-PST-E; IDENTIFIER: RN102907961; LOCATION: Henderson, Rusk County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to renew previously issued underground storage tank (UST) delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; and 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide corrosion protection for the UST system; PENALTY: $10,563; ENFORCEMENT COORDINATOR: Tiffany Chu, (817) 588-5891; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(7) COMPANY: QUAIL VALLEY COUNTRY LLC; DOCKET NUMBER: 2023-0911-PST-E; IDENTIFIER: RN102707932; LOCATION: Missouri City, Fort Bend County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30â€¯TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1) by failing to monitor the underground storage tanks (USTs) for releases in a manner which will detect a release at a frequency of at

least once every 30 days, and failing to provide release detection for the pressurized piping associated with the UST system; PENALTY: $4,621; ENFORCEMENT COORDINATOR: Eunice Adegelu, (512) 239-5082; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(8) COMPANY: Shubh Mahadev, Incorporated dba Amigo Mart; DOCKET NUMBER: 2023-0612-PST-E; IDENTIFIER: RN101284024; LOCATION: Santa Fe, Galveston County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.48(g)(1)(A)(ii) and TWC, §26.3475(c)(2), by failing to test the spill prevention equipment at least once every three years to ensure the equipment is liquid tight; 30 TAC §334.49(c)(2)(C) and (4)(C) and TWC, §26.3475(d), by failing to inspect the corrosion protection system at least once every 60 days to ensure that the rectifier and other system components are operating properly, and failing to test the corrosion protection system for operability and adequacy of protection at least once every three years; and 30 TAC §334.50(b)(1)(A) and (d)(9)(A)(iii) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks in a manner which will detect a release at a frequency of at least once every 30 days by taking appropriate steps to ensure that a statistical inventory reconciliation (SIR) analysis report is received from the vendor in no more than 15 calendar days following the last day of the 30-day period for which the SIR analysis is performed; PENALTY: $7,231; ENFORCEMENT COORDINATOR: Tiffany Chu, (817) 588-5891; REGIONAL OFFICE: 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(9) COMPANY: Texas Star Ready Mix, LLC; DOCKET NUMBER: 2022-1557-AIR-E; IDENTIFIER: RN111648234; LOCATION: Dallas, Dallas County; TYPE OF FACILITY: concrete batch plant; RULES VIOLATED: 30 TAC §116.110(a) and Texas Health and Safety Code, §382.0518(a) and §382.085(b), by failing to obtain authorization prior to constructing or modifying a source of air contaminants; PENALTY: $30,000; ENFORCEMENT COORDINATOR: Yuliya Dunaway, (210) 403-4077; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(10) COMPANY: The Praxis Companies, LLC; DOCKET NUMBER: 2023-0796-AIR-E; IDENTIFIER: RN102539145; LOCATION: Ennis, Ellis County; TYPE OF FACILITY: fiberglass tub and shower manufacturing plant; RULES VIOLATED: 30 TAC §122.143(4) and §122.146(2), Federal Operating Permit Number O2690, General Terms and Conditions and Special Terms and Conditions Number 8, and Texas Health and Safety Code, §382.085(b), by failing to submit a permit compliance certification within 30 days of any certification period; PENALTY: $3,250; ENFORCEMENT COORDINATOR: Karyn Olschesky, (817) 588-5896; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(11) COMPANY: W. L. Tillis, Jr. dba Tillis Tire and Detail; DOCKET NUMBER: 2023-0981-PST-E; IDENTIFIER: RN102839909; LOCATION: Crockett, Houston County; TYPE OF FACILITY: tire and detail shop; RULE VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum underground storage tanks; PENALTY: $3,160; ENFORCEMENT COORDINATOR: Eunice Adegelu, (512) 239-5082; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

TRD-202304375

Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: November 28, 2023

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Amended Consolidated Notice of Public Meeting, Receipt of Application and Intent to Obtain Permit and Notice of Application and Preliminary Decision Proposed Air Quality Permit No. 172856

APPLICATION. J7 Ready Mix, LLC, has applied to the Texas Commission on Environmental Quality (TCEQ) for the issuance of Permit No. 172856. This application would authorize construction of a Concrete Batch Plant located at 5428 East Farm to Market Road 1187, Burleson, Tarrant County, Texas 76028. **AVISO DE IDIOMA ALTERNATIVO.** El aviso de idioma alternativo en espanol está disponible en https://www.tceq.texas.gov/permitting/air/newsourcereview/airpermits-pendingpermit-apps. 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=-97.245393,32.579117&level=13. The proposed facility will emit the following air contaminants: particulate matter including (but not limited to) aggregate, cement, road dust, and particulate matter with diameters of 10 microns or less and 2.5 microns or less.

This application was submitted to the TCEQ on May 22, 2023. The executive director has completed the administrative and technical reviews of the application and determined that the application meets all of the requirements of a standard permit authorized by 30 TAC §116.611, which would establish the conditions under which the plant must operate. The executive director has made a preliminary decision to issue the registration because it meets all applicable rules. The application, executive director's preliminary decision, and standard permit will be available for viewing and copying at the TCEQ central office, the TCEQ Dallas/Fort Worth regional office, and at the *Crowley Public Library located at 409 South Oak Street, Crowley, Tarrant County,* Texas 76036 beginning the first day of publication of this notice. The facility's compliance file, if any exists, is available for public review at the TCEQ Dallas/Fort Worth Regional Office, 2309 Gravel Dr, Fort Worth, Texas. Visit www.tceq.texas.gov/goto/cbp to review the standard permit.

Public Comment/Public Meeting. You may submit public comments to the Office of the Chief Clerk at the address below. The TCEQ will hold a public meeting on this application because it was requested by a local legislator. The TCEQ will consider all public comments in developing a final decision on the application. A public meeting will be held and will consist of two parts, an Informal Discussion Period and a Formal Comment Period. A public meeting is not a contested case hearing under the Administrative Procedure Act. During the Informal Discussion Period, the public will be encouraged to ask questions of the applicant and TCEQ staff concerning the permit application. The comments and questions submitted orally during the Informal Discussion Period will not be considered before a decision is reached on the permit application, and no formal response will be made. Responses will be provided orally during the Informal Discussion Period. During the Formal Comment Period on the permit application, members of the public may state their formal comments orally into the official record. At the conclusion of the comment period, all formal comments will be considered before a decision is reached on the permit application. A written response to all formal comments will be prepared by the executive director and will be sent to each person who submits a formal comment or who requested to be on the mailing

list for this permit application and provides a mailing address. Only relevant and material issues raised during the Formal Comment Period can be considered if a contested case hearing is granted on this permit application.

The Public Meeting is to be held:

Monday, December 11, 2023 at 7:00 p.m.

Anchora Event Center, LLC

403 E Broad Street

Mansfield, Texas 76063

Persons with disabilities who need special accommodations at the meeting should call the Office of the Chief Clerk at (512) 239-3300 or (800) RELAY-TX (TDD) at least five business days prior to the meeting.

You may submit additional written public comments within 30 days of the date of newspaper publication of this notice in the manner set forth in the AGENCY CONTACTS AND INFORMATION paragraph below, or by the date of the public meeting, whichever is later. After the deadline for public comment, the executive director will consider the comments and prepare a response to all public comment. The response to comments, along with the executive director's decision on the application will be mailed to everyone who submitted public comments or is on a mailing list for this application.

Contested Case Hearing. You may request a contested case hearing. A contested case hearing is a legal proceeding similar to a civil trial in state district court. **Unless a written request for a contested case hearing is filed within 30 days from this notice, the executive director may approve the application.**

A person who may be affected by emissions of air contaminants from the facility is entitled to request a hearing. To request a hearing, a person must actually reside in a permanent residence within 440 yards of the proposed plant. If requesting 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; (2) applicant's name and registration number; (3) the statement "[I/we] request a contested case hearing;" (4) a specific description of how you would be adversely affected by the application and air emissions from the facility in a way not common to the general public; (5) the location and distance of your property relative to the facility; (6) a description of how you use the property which may be impacted by the facility; and (7) a list of all disputed issues of fact that you submit during the comment period. If the request is made by a group or association, one or more members who have standing to request a hearing must be identified by name and physical address. The interests which the group or association seeks to protect must be identified. You may submit your proposed adjustments to the application which would satisfy your concerns. See Contacts section.

TCEQ Action. After the deadline for public comments, the executive director will consider the comments and prepare a response to all relevant and material, or significant public comments. The executive director's decision on the application, and any response to comments, will be mailed to all persons on the mailing list. If no timely contested case hearing requests are received, or if all hearing requests are withdrawn, the executive director may issue final approval of the application. If all timely hearing requests are not withdrawn, the executive director will not issue final approval of the permit and will forward the application and requests to the 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 relating to relevant and material air quality concerns submitted during the comment period.** Issues such as property values, noise, traffic safety, and zoning are outside of the Commission's jurisdiction to address in this proceeding.

MAILING LIST. You may ask to be placed on a mailing list to receive additional information on this specific application by sending a written request to the Office of the Chief Clerk. See Contacts section.

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 link, enter the permit number at the top of this notice.

CONTACTS. 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 application or the permitting process, please call the TCEQ 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 J7 Ready Mix, LLC, 5515 E Highway 67, Alvarado, Texas 76009-6818 or by calling Mr. Chad Nerren, Project Manager at (936) 635-6524.

Amended Notice Issuance Date: November 17, 2023

TRD-202304362
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 2023

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Combined Notice of Public Meeting and Notice of Receipt of Application and Intent to Obtain Water Quality Permit and Notice of Application and Preliminary Decision for Water Quality Land Application Permit for Municipal Wastewater New Permit No. WQ0016281001

APPLICATION AND PRELIMINARY DECISION. Gram Vikas Partners, Inc., 1141 N Loop 1604 E 105-605, San Antonio, Texas 78232, has applied to the Texas Commission on Environmental Quality (TCEQ) for a new Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0016281001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 300,000 gallons per day. TCEQ received this application on January 10, 2023.

This combined notice is being issued due to an error in the previous notices regarding the address for the applicant.

The facility will be located approximately 0.2 miles west of the intersection of County Road 341 and County Road 442, in Medina County, Texas 78861. This 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. For the exact location, refer to the application.

https://gisweb.tceq.texas.gov/LocationMapper/?marker=-99.144444,29.380277&level=18

The treated effluent will be discharged directly to Hondo Creek in Segment No. 2114 of the Nueces River Basin. The designated uses for Segment No. 2114 are primary contact recreation, public water supply, aquifer protection, and high aquatic life use. In accordance with 30 Texas Administrative Code §307.5 and the TCEQ *Procedures to Implement the Texas Surface Water Quality Standards* (June 2010), an antidegradation review of the receiving waters was performed. A Tier 1 antidegradation review has preliminarily determined that existing water quality uses will not be impaired by this permit action. Numerical and narrative criteria to protect existing uses will be maintained. A Tier 2 review has preliminarily determined that no significant degradation of water quality is expected in Hondo Creek, which has been identified as having high aquatic life uses. Existing uses will be maintained and protected. The preliminary determination can be reexamined and may be modified if new information is received.

The TCEQ Executive Director has completed the technical review of the application and prepared a draft permit. The draft permit, if approved, would establish the conditions under which the facility must operate. The Executive Director has made a preliminary decision that this permit, if issued, meets all statutory and regulatory requirements. The permit application, Executive Director's preliminary decision, and draft permit are available for viewing and copying at Hondo Public Library, 2003 Avenue K, Hondo, Texas.

ALTERNATIVE LANGUAGE NOTICE. Alternative language notice in Spanish is available at *https://www.tceq.texas.gov/permitting/wastewater/plain-language-summaries-and-public-notices.* El aviso de idioma alternativo en español está disponible en *https://www.tceq.texas.gov/permitting/wastewater/plain-language-summaries-and-public-notices.*

PUBLIC COMMENT / PUBLIC MEETING. A public meeting will be held and will consist of two parts, an Informal Discussion Period and a Formal Comment Period. A public meeting is not a contested case hearing under the Administrative Procedure Act. During the Informal Discussion Period, the public will be encouraged to ask questions of the applicant and TCEQ staff concerning the permit application. The comments and questions submitted orally during the Informal Discussion Period will not be considered before a decision is reached on the permit application and no formal response will be made. Responses will be provided orally during the Informal Discussion Period. During the Formal Comment Period on the permit application, members of the public may state their formal comments orally into the official record. A written response to all timely, relevant and material, or significant comments will be prepared by the Executive Director. All formal comments will be considered before a decision is reached on the permit application. A copy of the written response will be sent to each person who submits a formal comment or who requested to be on the mailing list for this permit application and provides a mailing address. Only relevant and material issues raised during the Formal Comment Period can be considered if a contested case hearing is granted on this permit application.

The Public Meeting is to be held:

Tuesday, January 9, 2024, at 7:00 p.m.

Graff 7A Event Barn

911 US Hwy 90 E

Hondo, Texas 78861

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 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 a contested case hearing or reconsideration of the Executive Director's decision.** A contested case hearing is a legal proceeding similar to a civil trial in a 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 proposed permit number; the location and distance of your property/activities relative to the proposed 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 proposed 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 relating to relevant and material water quality concerns submitted during the comment period.**

EXECUTIVE DIRECTOR ACTION. The Executive Director may issue final approval of the application unless a timely contested case hearing request or request for reconsideration is filed. If a timely hearing request or request for reconsideration is filed, the Executive Director will not issue final approval of the permit and will forward the application and request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

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 specific 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. If you wish 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.

All written public comments and public meeting requests must be submitted to the Office of the Chief Clerk, MC 105, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087 or electronically at *www.tceq.texas.gov/goto/comment* within 30 days from the date of newspaper publication of this notice.

INFORMATION AVAILABLE ONLINE. For details about the status of the application, visit the Commissioners' Integrated Database at *www.tceq.texas.gov/goto/cid.* Search the database using the permit number for this application, which is provided at the top of this notice.

AGENCY CONTACTS AND INFORMATION. Public comments and requests must be submitted either electronically at *www.tceq.texas.gov/goto/comment,* 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. Any personal information you submit to the TCEQ will become part of the agency's record; this includes email addresses. For more information about this permit application or the permitting process, please call the TCEQ 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 Gram Vikas Partners, Inc. at the address stated above or by calling Mr. Kelly Leach at (210) 827-7918.

Issuance Date: November 21, 2023

TRD-202304364
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 2023

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Enforcement Orders

An agreed order was adopted regarding Silva Industries, LLC, Docket No. 2021-0912-WQ-E on November 21, 2023 assessing $1,425 in administrative penalties with $285 deferred. Information concerning any aspect of this order may be obtained by contacting Shane Glantz, 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 ASHBY CAPITAL INVESTMENTS, LLC, Docket No. 2021-1020-EAQ-E on November 21, 2023 assessing $6,500 in administrative penalties with $1,300 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 SM Wagner, LLC, Docket No. 2021-1348-EAQ-E on November 21, 2023 assessing $7,500 in administrative penalties with $1,500 deferred. Information concerning any aspect of this order may be obtained by contacting Mark Gamble, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding THE BUILDERS GROUP, LLC, Docket No. 2021-1607-WQ-E on November 21, 2023 assessing $4,000 in administrative penalties with $800 deferred. Information concerning any aspect of this order may be obtained by contacting Madison Stringer, 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 City of Palmer, Docket No. 2022-0146-MWD-E on November 21, 2023 assessing $6,750 in administrative penalties with $1,350 deferred. Information concerning any aspect of this order may be obtained by contacting Harley Hobson, 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 YETI INVESTMENT LLC, Docket No. 2022-0177-PST-E on November 21, 2023 assessing $3,375 in administrative penalties with $675 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 Nameless Hollow Council of Co-Owners, Docket No. 2022-0276-PWS-E on November 21, 2023 assessing $4,550 in administrative penalties with $910 deferred. 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 DALLARDSVILLE-SEGNO WATER SUPPLY CORPORATION, Docket No. 2022-0463-MLM-E on November 21, 2023 assessing $1,800 in administrative penalties with $360 deferred. Information concerning any aspect of this order may be obtained by contacting Samantha Salas, 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 Elgin-Butler Brick Company, LLC, Docket No. 2022-0997-WQ-E on November 21, 2023 assessing $3,983 in administrative penalties with $796 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 IEA Constructors, LLC, Docket No. 2022-1482-WQ-E on November 21, 2023 assessing $5,975 in administrative penalties with $1,195 deferred. Information concerning any aspect of this order may be obtained by contacting Mistie Gonzales, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Kopperl ISD, Docket No. 2022-1567-MWD-E on November 21, 2023 assessing $1,350 in administrative penalties with $270 deferred. Information concerning any aspect of this order may be obtained by contacting Mistie Gonzales, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding PERMIAN LODGING MONAHANS LLC, Docket No. 2022-1705-MWD-E on November 21, 2023 assessing $1,625 in administrative penalties with $325 deferred. Information concerning any aspect of this order may be obtained by contacting Cheryl Thompson, 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 Duran Apartment Management Inc, Docket No. 2023-0457-UTL-E on November 21, 2023 assessing $500 in administrative penalties with $100 deferred. Information concerning any aspect of this order may be obtained by contacting Claudia Bartley, 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 U. S. LAND CORP., Docket No. 2023-0534-UTL-E on November 21, 2023 assessing $470 in administrative penalties with $94 deferred. Information concerning any aspect of this order may be obtained by contacting Kaisie Hubschmitt,

Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding The George R. Brown Partnership, L.P., Docket No. 2023-0635-AIR-E on November 21, 2023 assessing $2,000 in administrative penalties with $400 deferred. Information concerning any aspect of this order may be obtained by contacting Desmond Martin, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding The George R. Brown Partnership, L.P., Docket No. 2023-0665-AIR-E on November 21, 2023 assessing $4,000 in administrative penalties with $800 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0666-AIR-E on November 21, 2023 assessing $1,625 in administrative penalties with $325 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0667-AIR-E on November 21, 2023 assessing $1,625 in administrative penalties with $325 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0685-AIR-E on November 21, 2023 assessing $4,000 in administrative penalties with $800 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0686-AIR-E on November 21, 2023 assessing $4,500 in administrative penalties with $900 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0687-AIR-E on November 21, 2023 assessing $1,625 in administrative penalties with $325 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0716-AIR-E on November 21, 2023 assessing $4,500 in administrative penalties with $900 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, 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 The George R. Brown Partnership, L.P., Docket No. 2023-0779-AIR-E on November 21, 2023 assessing $1,625 in administrative penalties with $325 deferred. Information concerning any aspect of this order may be obtained by contacting Karyn Olschesky, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was adopted regarding Thompson, Wesley, Docket No. 2023-1122-WOC-E on November 21, 2023 assessing $175 in administrative penalties. Information concerning any aspect of this citation may be obtained by contacting Celicia Garza, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A field citation was adopted regarding Pico Propane Operating, LLC, Docket No. 2023-1139-WQ-E on November 21, 2023 assessing $875 in administrative penalties. Information concerning any aspect of this citation 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.

A field citation was adopted regarding White, Cody L., Docket No. 2023-1141-WOC-E on November 21, 2023 assessing $175 in administrative penalties. Information concerning any aspect of this citation may be obtained by contacting Daphne Greene, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-202304365
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 2023

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Enforcement Orders

An agreed order was adopted regarding Richard Thomas, Docket No. 2020-0630-WQ-E on November 29, 2023 assessing $10,500 in administrative penalties with $9,300 deferred. Information concerning any aspect of this order may be obtained by contacting William Hogan, 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 Hawk Cove, Docket No. 2021-0024-MWD-E on November 29, 2023 assessing $39,525 in administrative penalties with $7,905 deferred. Information concerning any aspect of this order may be obtained by contacting Mistie Gonzales, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Carol Mahan and Tanner Mahan, Docket No. 2021-0287-WR-E on November 29, 2023 assessing $2,400 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Clayton Smith, 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 Holly P. Wright and Tyler O. Wright, Docket No. 2021-0287-WR-E on November 29, 2023 assessing $2,400 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Clayton Smith, 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 LION ELASTOMERS LLC, Docket No. 2021-0875-AIR-E on November 29, 2023 assessing $59,376 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Amanda Diaz,

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 Casco Hauling & Excavating Co., Docket No. 2021-1309-MSW-E on November 29, 2023 assessing $38,543 in administrative penalties with $7,708 deferred. Information concerning any aspect of this order may be obtained by contacting Horus Garcia, 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 Zenon Soto dba Soto's Paint & Body Shop, Docket No. 2021-1495-AIR-E on November 29, 2023 assessing $5,000 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Taylor Pack Ellis, 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 Ranger, Docket No. 2021-1533-MWD-E on November 29, 2023 assessing $27,125 in administrative penalties with $5,425 deferred. Information concerning any aspect of this order may be obtained by contacting Harley Hobson, 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 Nutrien US LLC f/k/a Agrium U.S. Inc., Docket No. 2021-1562-AIR-E on November 29, 2023 assessing $50,938 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was adopted regarding Town of Sunnyvale, Docket No. 2022-0137-WQ-E on November 29, 2023 assessing $9,000 in administrative penalties with $1,800 deferred. Information concerning any aspect of this order may be obtained by contacting Cheryl Thompson, 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 Sodolaks Properties, LLC, Docket No. 2022-0278-PST-E on November 29, 2023 assessing $8,497 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting William Hogan, 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 North Texas Municipal Water District, Docket No. 2022-0855-MWD-E on November 29, 2023 assessing $14,250 in administrative penalties. Information concerning any aspect of this order may be obtained by contacting Harley Hobson, 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 City of Galveston, Docket No. 2023-0267-PWS-E on November 29, 2023 assessing $17,250 in administrative penalties with $3,450 deferred. 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 THE LUBRIZOL CORPORATION, Docket No. 2023-0393-AIR-E on November 29, 2023 assessing $26,250 in administrative penalties with $5,250 deferred. Information concerning any aspect of this order may be obtained by contacting Johnnie Wu, 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 Moore Water Supply Corporation, Docket No. 2023-0415-MWD-E on November 29, 2023 assessing $8,525 in administrative penalties with $1,705 deferred. Information concerning any aspect of this order may be obtained by contacting Shane Glantz, Enforcement Coordinator at (512) 239-2545, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-202304396
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 29, 2023

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Notice and Comment Hearing Draft Permit No.: O1553

This is a notice for a notice and comment hearing on Federal Operating Permit Number O1553. During the notice and comment hearing informal questions on the Federal Operating Permit will be answered and formal comments will be received. The Texas Commission on Environmental Quality (TCEQ) has scheduled the notice and comment hearing regarding this application and draft permit as follows:

Date: February 5, 2024

Time: 6 p.m.

Location: Marriott SpringHill Suites Baytown

5169 I-10 East

Baytown, Texas 77521

Location phone: (281) 421-1200

Application and Draft Permit. Exxon Mobil Corporation, P.O. Box 100, Baytown, Texas 77522-0100, an All Other Basic Organic Chemical Manufacturing facility, has applied to the TCEQ for a Renewal of Federal Operating Permit (herein referred to as permit) No. O1553, Application No. 23071 to authorize operation of the Baytown Olefins Plant. The area addressed by the application is located at 3525 Decker Drive in Baytown, Harris County, Texas 77520-1646. This application was received by the TCEQ on June 26, 2015.

The TCEQ Executive Director has completed the technical review of the application and prepared a draft permit. The draft permit, if approved, will codify the conditions under which the site must operate. The TCEQ Executive Director recommends issuance of the draft permit. The purpose of a federal operating permit is to improve overall compliance with the rules governing air pollution control by clearly listing all applicable requirements, as defined in Title 30 Texas Administrative Code (30 TAC) §122.10. The permit will not authorize new construction or new emissions.

Notice and Comment Hearing. The hearing will be structured for the receipt of oral or written comments by interested persons. Registration and an informal discussion period with commission staff members will begin during the first 30 minutes. During the informal discussion period, the public is encouraged to ask questions and engage in open discussion with the applicant and the TCEQ staff concerning this application and draft permit. Issues raised during this discussion period **will only** be addressed in the formal response to comments if the issue is also presented during the hearing. After the conclusion of the informal discussion period, the TCEQ will conduct a notice and comment hearing regarding the application and draft permit. Individuals may present oral statements when called upon in order of registration. A five-minute time limit may be established at the hearing to assure that enough time is allowed for every interested person to speak. There will

be no open discussion during the hearing; however, commission staff members will be available to discuss the proposal and answer questions after the hearing. The purpose of this hearing will be to receive formal public comment which the TCEQ will consider in determining whether to revise and/or issue the permit and in determining the accuracy and completeness of the permit. Any person may attend this meeting and submit written or oral comments. The hearing will be conducted in accordance with the Texas Clean Air Act § 382.0561, as codified in the Texas Health and Safety Code, and 30 TAC §122.340.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact the TCEQ Public Education Program toll free at (800) 687-4040 or (800) RELAY-TX (TDD), at least five business days prior to the hearing.

Any person may also submit written comments before the hearing to the Texas Commission on Environmental Quality, Office of Chief Clerk, MC-105, P.O. Box 13087, Austin, Texas 78711-3087, or electronically at www14.tceq.texas.gov/epic/eComment/. Written comments should include (1) your name, address, and daytime telephone number, and (2) the draft permit number found at the top of this notice.

A notice of proposed final action that includes a response to comments and identification of any changes to the draft permit will be mailed to everyone who submitted: written comments, and/or hearing requests, attended the hearing, or requested to be on the mailing list for this application. This mailing will also provide instructions for public petitions to the U.S. Environmental Protection Agency (EPA) to request that the EPA object to the issuance of the proposed permit. After receiving a petition, the EPA may only object to the issuance of a permit which is not in compliance with applicable requirements or the requirements of 30 TAC Chapter 122.

Mailing List. In addition to submitting public comments, a person may ask to be placed on a mailing list for this application by sending a request to the TCEQ Office of the Chief Clerk at the address above. Those on the mailing list will receive copies of future public notices (if any) mailed by the Chief Clerk for this application.

Information. For additional information about this permit application or the permitting process, please contact the Texas Commission on Environmental Quality, Public Education Program, MC-108, P.O. Box 13087, Austin, Texas 78711-3087 or toll free at (800) 687-4040. General information about the TCEQ can be found at www.tceq.texas.gov. Si desea información en español, puede llamar al (800) 687-4040.

Further information may also be obtained for Exxon Mobil Corporation by calling Santhosh Kapildev, BOP NSR Permitting & Title V Advisor at (254) 545-3949.

Notice Issuance Date: November 21, 2023

TRD-202304367
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 2023

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Notice of Informational Meeting on Petition for the Creation of Kaufman County Municipal Utility District No. 15 TCEQ Internal Control No. D-09072022-008

PETITION. Bellagio 443, LLC, a Wyoming limited liability company filed a petition for the creation of Kaufman County Municipal Utility District No. 15 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, § 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ.

The petition states that: (1) the Petitioners hold title to a majority in value of the land to be included in the proposed District; (2) there is one lienholder, Megatel Capital Investments, LLC, on the property to be included in the proposed District and the aforementioned entity has consented to the creation of the district; (3) the proposed District will contain approximately 445.993 acres of land located within Kaufman County, Texas; and (4) all of the land to be included within the proposed district is located wholly within the extraterritorial jurisdiction of the City of Mesquite, Texas

INFORMATIONAL MEETING. The TCEQ will conduct an informational meeting to answer questions and discuss the petition. Formal comments will not be taken at the informational meeting. The meeting will be held:

Thursday, December 14, 2023, at 7:00 p.m.

Best Western Plus - Christopher Inn & Suites

752 Pinson Road, Forney, Texas 75126

INFORMATION. For more information about this petition or the permitting process, please call the Public Education Program toll free at (800) 687-4040. General information can be found at our web site at www.tceq.texas.gov. Si desea información en español, puede llamar al (800) 687-4040.

Further information may also be obtained from CoatsRose, 16000 North Dallas Parkway, Suite 350, Dallas, Texas 75248, or by calling Ms. Mindy Koehne, attorney at (972) 788-1600.

Persons with disabilities who need special accommodations at the meeting should call the Office of the Chief Clerk at (512) 239-3300 or (800) RELAY-TX (TDD) at least five business days prior to the meeting.

Notice Issuance Date: November 20, 2023

TRD-202304363
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 2023

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Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075, requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075, requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 12, 2024.** TWC, §7.075, also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required

to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 12, 2024.** The designated attorneys are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075, provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: Belmont 407, LLC; DOCKET NUMBER: 2022-0645-WQ-E; TCEQ ID NUMBER: RN110642303; LOCATION: Old Justin Road and Cleveland Gibbs Road, Argyle, Denton County; TYPE OF FACILITY: residential housing development; RULES VIOLATED: 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) General Permit Number TXR15596U, 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; and 30 TAC §305.125(1) and TPDES General Permit Number TXR15596U, Part III, Section F.7(b)(iv), by failing to identify any incidents of noncompliance observed during the inspection; PENALTY: $1,788; STAFF ATTORNEY: Tracy Chandler, Litigation, MC 175, (512) 239-0629; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: TriStar Convenience Stores, Inc. dba Handi Stop 74; DOCKET NUMBER: 2021-0406-PST-E; TCEQ ID NUMBER: RN102445418; LOCATION: 612 Center Street, Deer Park, Harris County; TYPE OF FACILITY: underground storage tank (UST) system; RULE VIOLATED: 30 TAC §334.10(b)(2), by failing to assure that all UST recordkeeping requirements were met; PENALTY: $750; STAFF ATTORNEY: Barrett Hollingsworth, Litigation, MC 175, (512) 239-0657; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-202304376
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: November 28, 2023

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent the Executive Director's Preliminary Report and Petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 12, 2024.** The commission will consider any written comments received, and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 12, 2024.** The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075, provides that comments on the DO shall be submitted to the commission in **writing.**

(1) COMPANY: ALAUDDIN INVESTMENTS, INC. dba Kwik Trip Food Store; DOCKET NUMBER: 2022-1014-PST-E; TCEQ ID NUMBER: RN102466091; LOCATION: 551 Fredericksburg Road, San Antonio, Bexar County; TYPE OF FACILITY: out-of-service underground storage tank (UST) system and a convenience store; RULE VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed upgrade implementation date, a UST system for which any applicable component of the system is not brought into timely compliance with the upgrade requirements; PENALTY: $4,125; STAFF ATTORNEY: Taylor Pack Ellis, Litigation, MC 175, (512) 239-6860; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(2) COMPANY: FARMERS COOPERATIVE SOCIETY NO. 1 OF JAYTON, TEXAS; DOCKET NUMBER: 2021-1451-PST-E; TCEQ ID NUMBER: RN102548492; LOCATION: 217 East 2nd Street, Jayton, Kent County; TYPE OF FACILITY: underground storage tank (UST) system and a farmers' cooperative; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum USTs; TWC, §26.3475(d) and 30 TAC §334.49(c)(2)(C), by failing to inspect the impressed current cathodic protection system at least once every 60 days to ensure that the rectifier and system components are operating properly; TWC, §26.3475(d) and 30 TAC §334.49(c)(4)(C), by failing to have the cathodic protection system inspected and tested for operability and adequacy of protection at a frequency of at least once every three years; TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once every 30 days; TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide release detection for the pressurized piping associated with the UST system; and 30 TAC §334.606, by failing to maintain required operator training certification records and make them available for inspection upon request by agency personnel; PENALTY: $12,500; STAFF ATTORNEY: Jennifer Peltier, Litigation, MC 175, (512) 239-0544; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(3) COMPANY: RAYLEE TRUCKING SERVICES, INC.; DOCKET NUMBER: 2022-0764-MSW-E; TCEQ ID NUMBER:

RN102016235; LOCATION: 1501 Corsicana Highway, Hillsboro, Hill County; TYPE OF FACILITY: Emergency Response site; RULE VIOLATED: 30 TAC §327.5(c), by failing to submit written information describing the details of the discharge or spill and supporting the adequacy of the response action, to the appropriate TCEQ regional manager within 30 working days of the discovery of the reportable discharge or spill; PENALTY: $2,625; STAFF ATTORNEY: Casey Kurnath, Litigation, MC 175, (512) 239-5932; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(4) COMPANY: Rickey Evans, Jr.; DOCKET NUMBER: 2021-1263-WQ-E; TCEQ ID NUMBER: RN111035309; LOCATION: south of Farm-to-Market Road 1844, Longview, Gregg County; TYPE OF FACILITY: construction site; RULES VIOLATED: 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) General Permit Number TXR1581CB, Part III, Section D.2, by failing to maintain the TCEQ site notice near the main entrance of the construction site; 30 TAC §305.125(1) and TPDES General Permit Number TXR1581CB, Part III, Section F.7(a) and (e), by failing to conduct inspections of disturbed areas as specified in the permit; 30 TAC §305.125(1) and TPDES General Permit Number TXR1581CB, Part III, Section F.2(b)(iii), by failing to initiate erosion control and stabilization measures where construction activities have temporarily ceased and will not resume within 14 days or where construction activities have permanently ceased; and 30 TAC §305.125(1) and TPDES General Permit Number TXR1581CB, Part III, Section F.6(c), by failing to maintain sediment traps and sedimentation ponds; PENALTY: $4,987; STAFF ATTORNEY: William Hogan, Litigation, MC 175, (512) 239-5918; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

TRD-202304377
Gitanjali Yadav
Deputy Director, Litigation
Texas Commission on Environmental Quality
Filed: November 28, 2023

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Notice of Receipt of Application and Intent to Obtain Municipal Solid Waste Major Permit Amendment

Notice mailed on November 28, 2023

Proposed Permit No. 66C

Application. Waste Management of Texas, Inc. has applied to the Texas Commission on Environmental Quality (TCEQ) for a major permit amendment to authorize a lateral landfill expansion to increase the size and waste disposal volume (capacity) of the facility. In addition to waste disposal, waste processing (including liquid waste solidification) and storage will occur onsite. The facility is located at 1700 Kohlenberg Road, New Braunfels, 78130 in both Comal and Guadalupe Counties, Texas. The TCEQ received this application on October 26, 2023. The permit application is available for viewing and copying at the New Braunfels Public Library, 700 East Common Street, New Braunfels, Texas 78130 in Comal County and at the Seguin Public Library, 313 West Nolte Street, Seguin, Texas 78155 in Guadalupe County and may be viewed online at https://prj.geosyntec.com/TXPermits/MesquiteCreekLandfill.aspx. The following link to an electronic map of the site or facility general location is provided as a public courtesy and is not part of the application or notice: https://arcg.is/nTrme. For exact location, refer to the application.

Alternative Language Notice/Aviso sobre lenguas alternativas. Alternative language notice in Spanish is available at www.tceq.texas.gov/goto/mswapps. Hay disponible un aviso en español en www.tceq.texas.gov/goto/mswapps.

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 Waste Management of Texas, Inc. at the mailing address 1700 Kohlenberg Road, New Braunfels, Texas 78130 or by calling James Smith at (512) 748-4235.

TRD-202304393
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 29, 2023

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Notice of Receipt of Application and Intent to Obtain Municipal Solid Waste Permit Amendment

Notice mailed on November 28, 2023

Proposed Limited Scope Amendment to Permit No. 2348

Application. Desarrollo del Rancho La Gloria TX, a Type I municipal solid waste landfill, has applied to the Texas Commission on Environmental Quality (TCEQ) for a permit amendment to authorize the re-characterization of groundwater flow conditions and addition of new groundwater monitor wells to adequately monitor the groundwater below the site. The facility is located near the intersection of Mile 14 and FM 681 due north of Moorfield in Hidalgo County, Texas. The TCEQ received this application on October 18, 2023. The permit application is available for viewing and copying at the McAllen Public Library, 4001 North 23rd Street, McAllen, Hidalgo County, Texas 78504, and may be viewed online at http://downloads.cecinc.com/LaGloria/. 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/4f9vS0. For exact location, refer to application.

Alternative Language Notice/Aviso de idioma alternativo. Alternative language notice in Spanish is available at www.tceq.texas.gov/goto/mswapps. La notificación en otro idioma en español está disponible en www.tceq.texas.gov/goto/mswapps.

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 Desarrollo del Rancho La Gloria TX at the mailing address 13630 Fondren Road, Houston, Texas 77085 or by calling Mr. Michael Derdeyn at (210) 951-3337.

TRD-202304392
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 29, 2023

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Notice of Receipt of Application and Intent to Obtain Municipal Solid Waste Permit Amendment

Notice mailed on November 28, 2023

Proposed Limited Scope Amendment to Permit No. 2316

Application. Maverick County has applied to the Texas Commission on Environmental Quality (TCEQ) for a permit amendment to authorize the correction of waste capacity of the Maverick County El Indio MSW Landfill. The facility is located at 16179 FM 1021, El Indio, 78860, in Maverick County, Texas. The TCEQ received this application on October 4, 2023. The permit application is available for viewing and copying at the Maverick County Courthouse, 500 Quarry Street, Suite 3, Eagle Pass, in Maverick County, Texas 78852, and may be viewed online at https://www.scsengineers.com/state/maverick-county-el-indio-landfill/. 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/1qWKGq0. For exact location, refer to application.

Alternative Language Notice/Aviso de idioma alternativo. Alternative language notice in Spanish is available at www.tceq.texas.gov/goto/mswapps. La notificación en otro idioma en español está disponible en www.tceq.texas.gov/goto/mswapps.

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 Maverick County at the mailing address 500 Quarry Street, Suite 3, Eagle Pass, Texas 78852 or by calling Mr. Mike Castillo, Landfill Manager, at (830) 757-8191.

TRD-202304394
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 29, 2023

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Notice of Water Quality Application

The following notice was issued on November 21, 2023:

The following notice does not require publication in a newspaper. Written comments or requests for a public meeting may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin Texas 78711-3087 WITHIN (30) DAYS FROM THE DATE THIS NOTICE IS PUBLISHED IN THE *TEXAS REGISTER.*

INFORMATION SECTION

Freestone Power Generation, LLC and Calpine Operating Services Company, Inc., which operates the Freestone Power Generation Plant, a combined cycle electric power generation facility, has applied for a minor amendment to Texas Pollutant Discharge Elimination System Permit No. WQ0004298000 to re-locate Outfall 001. The draft permit authorizes the discharge of cooling tower blowdown, low volume waste sources, and stormwater at a daily average flow not to exceed 1,250,000 gallons per day via Outfall 001. The facility is located at 1366 Farm-to-Market Road 488, near the City of Fairfield, Freestone County, Texas 75840.

TRD-202304366
Laurie Gharis
Chief Clerk
Texas Commission on Environmental Quality
Filed: November 27, 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 November 13, 2023 to November 17, 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 §§30.20(f), 30.30(h), and 30.40(e), 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, December 1, 2023. The public comment period for this project will close at 5:00 p.m. on December 31, 2023.

Federal License and Permit Activities:

Applicant: Plains Marketing, L.P.

Location: The project site is located within the Corpus Christi Ship Channel, in Corpus Christi, Nueces County, Texas. Eleven dredge material placement areas (DMPA) locations are scattered throughout the Corpus Christi Bay area.

Latitude and Longitude: 27.815354, -97.463111

Project Description: The applicant proposes to perform dredging operations on the previously authorized and constructed dock slip including the slip's side/end slopes. Further the applicant wishes to extend maintenance dredging 10 years. The applicant requests the use of silt blade, mechanical, or hydraulic dredging methods and to increase and maintain the overall dredging depth to elevation (-) 51 feet NAV88, with an allowable overdepth of elevation (-) 53 feet NAVD88 within the slip. An estimated up to 52,346 cubic yards of material will be dredged to achieve elevation (-) 51 feet NAVD88 within the slip, and with side/end slopes dredged on a 2.5 horizontal to 1 vertical grade. An additional estimated 22,297 cubic yards is requested to be dredged below the required depth of the slip and slopes from within a 2-foot allowable overdepth area to a maximum depth of elevation (-) 53 feet NAVD 88, for a total of an estimated 74,643 cubic yards of dredging. The applicant would like authorization to use six previously authorized DMPAs as well five additional DMPAs as to place dredged material from the ship dock basin. Proposed DMPAs consist of Suntide DMPA, Tule Lake DMPA No. 6, South Shore DMPA - Cells A & B, DMPA No. 1, Herbie A. Maurer DMPA, Rincon B West, DMPA 14, DMPA 13, and Good Hope DMPA Cell J and Cell I. The applicant does not propose compensatory mitigation.

Type of Application: U.S. Army Corps of Engineers permit application # SWG-2014-00260. 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 Railroad Commission of Texas as part of its certification under §401 of the Clean Water Act.

CMP Project No: 24-1067-F1

Applicant: Texas International Terminals LTD (TXIT)

Location: The project site is located in the Galveston Ship Channel, east of the Pelican Island Causeway, at 4800 Port Industrial Road, in Galveston, Galveston County, Texas.

Latitude and Longitude: 29.307877, -94.822815

Project Description: The applicant proposes modification to previously authorized Permit SWG-2012-00602 to authorize additional dredging of approximately 160,000 cubic yards (CY) of new work material from the TXIT Berth to create an 11-acre siltation basin within the existing, previously authorized 33-acre TXIT Berth that would be dredged to -51 feet mean lower low water (MLLW). Previously authorized placement areas are onsite: PA50, San Jacinto, Pelican Island DMPA, five Port of Galveston (POG) former ship slips (#12, #14, #37, #39, and #41) and the POG PA. Additionally, the applicant is requesting authorization to place the dredge material at the USACE Pelican Island Beneficial Use (BU) Site and the continued authorization for 10 years of maintenance dredging from the berth, including the siltation basin within the berth. Annually, approximately 250,000 CY of maintenance material is proposed to be placed in any of the previously authorized areas and in addition of Pelican Island

BU area. The purpose of the proposed siltation basin is to capture sediment that leads to the excessive accumulation of silt in the berth, resulting in unsafe navigation conditions. The applicant is not proposing mitigation as the proposed work is only associated with dredging activities and the placement of the dredge material for beneficial use.

Type of Application: U.S. Army Corps of Engineers permit application # SWG-2012-00602. 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: 24-1073-F1

Applicant: Deer Park Refining, LP

Location: The project site is located along the south shore and open waters of the Houston Ship Channel (Buffalo Bayou), adjacent to the PEMEX facility, in Deer Park, Harris County, Texas.

Latitude and Longitude: 29.732958, -95.122961

Project Description: The applicant proposes to expand an existing bulkhead and install a new pier for mooring a privately owned fire-fighting boat. Specifically, the applicant proposes to install a new 624 linear foot bulkhead and 740 cubic yards of fill material waterward of the high tide line and existing bulkhead structure; the existing bulkhead will be left in place. Additionally, the applicant proposes to demolish an existing fireboat dock and install new structure consisting of a 124' 4" long x 6' wide (106' 7" x 6' over waters) pier supported walkway leading to a 554 square foot mooring dock (55' 5" at widest x 14' 2" long). Lastly the applicant proposes installing 6 dolphins, consisting of a 24" diameter steel monopiles, waterward of the newly installed dock for the purpose of protecting the dock and mooring vessels; piles will be driven approximately 80 feet below the high-tide line into the substrate. The docking structure is not proposed to be covered and will be supported by piles driven approximately 30-40 feet below the high-tide line into the substrate.

The applicant has not proposed compensatory mitigation. The applicant has provided the flowing statement relating to mitigation: "We do not believe that compensation/ mitigation is required for this project, as only 740 CY of fill will be discharged in front of an existing bulkhead, displacing a minimal amount of water. The new pier will not cause a loss of public waters or impact to navigation."

Type of Application: U.S. Army Corps of Engineers permit application # SWG-2023-00464. 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 Texas Commission on Environmental Quality as part of its certification under §401 of the Clean Water Act.

CMP Project No: 24-1077-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-202304398
Mark Havens
Chief Clerk
General Land Office
Filed: November 29, 2023

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Texas Health and Human Services Commission

Public Notice - Texas State Plan for Medical Assistance Amendment

The Texas Health and Human Services Commission (HHSC) announces its intent to submit amendments to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendments will be effective January 1, 2024.

The purpose of the amendments is to update the fee schedules in the current state plan by adjusting fees, rates, or charges for the following services:

2024 Annual Healthcare Common Procedure Coding System (HCPCS) Updates:

Ambulance Services;

Ambulatory Surgical Center;

Birthing Center Facility Services;

Case Management Services;

Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners;

Certified Registered Nurse Anesthetists and Anesthesiologist Assistants;

Clinical Diagnostic Laboratory Services;

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS);

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT);

Family Planning Services;

Hearing Aids and Audiometric Evaluations;

Home Health Services;

Indian Health Services;

Licensed Clinical Social Worker Services;

Licensed Professional Counselor Services;

Licensed Marriage and Family Therapist Services;

Physicians and Other Practitioners;

Physician Assistants;

Rehabilitative Chemical Dependency Treatment Facility Services; and

Vision Care Services.

The proposed amendment is estimated to result in an annual aggregate expenditure of $311,760 for federal fiscal year (FFY) 2024, consisting of $187,524 in federal funds and $124,236 in state general revenue. For FFY 2025, the estimated annual aggregate expenditure is $411,273 consisting of $248,820 in federal funds and $162,453 in state general revenue. For FFY 2026, the estimated annual aggregate expenditure is $406,913 consisting of $246,182 in federal funds and $160,731 in state general revenue.

Further detail on specific reimbursement rates and percentage changes will be made available on the HHSC Provider Finance website under the proposed effective date at: https://pfd.hhs.texas.gov/rate-packets.

Rate Hearings.

A Rate hearing will be conducted either online or both in person and online in February 2024, to address the 2024 Annual Healthcare Common Procedures Coding System (HCPCS) Updates. Once available, information about the proposed rate changes and the hearing will be published in a subsequent issue of the *Texas Register* at http://www.sos.state.tx.us/texreg/index.shtml.

Copy of Proposed Amendment.

Interested parties may obtain additional information and/or a free copy of the proposed amendment by contacting Nicole Hotchkiss, State Plan Policy Advisor, by mail at the Health and Human Services Commission, P.O. Box 13247, Mail Code H-600, Austin, Texas 78711; by telephone at (512) 487-3349; by facsimile at (512) 730-7472; or by e-mail at Medicaid_Chip_SPA_Inquiries@hhsc.state.tx.us. Copies of the proposed amendment will be available for review at the local county offices of HHSC, (which were formerly the local offices of the Texas Department of Aging and Disability Services).

Written Comments.

Written comments about the proposed amendment and/or requests to review comments may be sent by U.S. mail, overnight mail, special delivery mail, hand delivery, fax, or email:

U.S. Mail Texas Health and Human Services Commission Attention: Provider Finance Department

Mail Code H-400 P.O. Box 149030 Austin, Texas 78714-9030

Overnight mail, special delivery mail, or hand delivery Texas Health and Human Services Commission Attention: Provider Finance Department

North Austin Complex

Mail Code H-400 4601 W. Guadalupe St.

Austin, Texas 78751

Phone number for package delivery: (512) 730-7401

Fax Attention: Provider Finance at (512) 730-7475

Email PFDAcuteCare@hhs.texas.gov

Preferred Communication.

For quickest response, please use e-mail or phone, if possible, for communication with HHSC related to this state plan amendment.

If an in-person hearing is necessary, persons with disabilities who wish to attend 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-202304399
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: November 29, 2023

♦ ♦ ♦

Texas Department of Insurance

Company Licensing

Application to do business in the state of Texas for Concept Program Management, Inc., a foreign fire and/or casualty company. The home office is in Omaha, Nebraska.

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-202304361
Justin Beam
Chief Clerk
Texas Department of Insurance
Filed: November 27, 2023

♦ ♦ ♦

Company Licensing

Application to do business in the state of Texas for Bridgefield Indemnity Insurance Company, a foreign fire and/or casualty company. The home office is in Cincinnati, Ohio.

Application for incorporation in the state of Texas for Texicare Health Insurance Company, a domestic life, accident, and/or health insurance company. The home office is in Austin, Texas.

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-202304395
Justin Beam
Chief Clerk
Texas Department of Insurance
Filed: November 29, 2023

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Texas Lottery Commission

Scratch Ticket Game Number 2504 "CROSSWORD"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2504 is "CROSSWORD". The play style is "crossword".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2504 shall be $3.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2504.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z and GRID BOX 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. 2504 - 1.2D

PLAY SYMBOL	CAPTION
A	
B	
C	
D	
E	
F	
G	
H	
I	
J	
K	
L	
M	
N	
O	
P	
Q	
R	
S	
T	
U	
V	
W	
X	
Y	
Z	
GRID BOX SYMBOL	

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 (2504), 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: 2504-0000001-001.

H. Pack - A Pack of the "CROSSWORD" Scratch Ticket Game contains 125 Tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be 2 fanfold configurations for this game. Configuration A will show the front of Ticket 001 and the back of Ticket 125. Configuration B will show the back of Ticket 001 and the front of Ticket 125.

I. Non-Winning Scratch Ticket - A Scratch Ticket which is not programmed to be a winning Scratch Ticket or a Scratch Ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

J. Scratch Ticket Game, Scratch Ticket or Ticket - Texas Lottery "CROSSWORD" Scratch Ticket Game No. 2504.

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 "CROSSWORD" 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 forty-one (141) Play Symbols. A player completely scratches all of the YOUR 20 LETTERS Play Symbols. Then the player scratches all the letters found in the CROSSWORD puzzle that exactly match the YOUR 20 LETTERS Play Symbols. If the player has scratched at least 3 complete WORDS, the player wins the prize found in the PRIZE LEGEND. Only 1 prize is paid per Ticket. Only letters with the CROSSWORD puzzle that are matched with the YOUR 20 LETTERS Play Symbols can be used to form a complete WORD. Every letter within an unbroken horizontal (left to right) or vertical (top to bottom) sequence must be matched with the YOUR 20 LETTERS Play Symbols to be considered a complete WORD. Words revealed in a diagonal sequence are not considered valid WORDS. Words within WORDS are not eligible for a prize. Words that are spelled from right to left or bottom to top are not eligible for a prize. A complete WORD must contain at least 3 letters. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly one hundred forty-one (141) 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 forty-one (141) 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 forty-one (141) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the one hundred forty-one (141) 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: There is no correlation between any exposed data on a ticket and its status as a winner or non-winner.

C. CROSSWORD GAMES: The grid on each Ticket will contain exactly the same number of letters.

D. CROSSWORD GAMES: The grid on each Ticket will contain exactly the same number of words.

E. CROSSWORD GAMES: There will be no matching words on a Ticket.

F. CROSSWORD GAMES: All words used will be from the TX APPROVED WORDS v.2.042321, dated April 23, 2021.

G. CROSSWORD GAMES: All words will contain a minimum of three (3) letters.

H. CROSSWORD GAMES: All words will contain a maximum of nine (9) letters.

I. CROSSWORD GAMES: There will be a minimum of three (3) vowels in the YOUR 20 LETTERS play area. Vowels are considered to be A, E, I, O, U.

J. CROSSWORD GAMES: No consonant will appear more than nine (9) times, and no vowel will appear more than fourteen (14) times in the grid.

K. CROSSWORD GAMES: There will be no matching Play Symbols in the YOUR 20 LETTERS play area.

L. CROSSWORD GAMES: At least fifteen (15) of the letters in the YOUR 20 LETTERS play area will open at least one (1) letter in the grid.

M. CROSSWORD GAMES: The presence or absence of any letter or combination of letters in the YOUR 20 LETTERS play area will not be indicative of a winning or Non-Winning Ticket.

N. CROSSWORD GAMES: Words from the TX PROHIBITED WORDS v.2.042321, dated April 23, 2021, will not appear horizontally in the YOUR 20 LETTERS play area when read left to right or right to left.

O. CROSSWORD GAMES: On Non-Winning Tickets, there will be two (2) completed words in the grid.

P. CROSSWORD GAMES: There will be a random distribution of all Play Symbols on the Ticket, unless restricted by other parameters, play action or prize structure.

Q. CROSSWORD GAMES: There will be no more than twelve (12) complete words in the grid.

R. CROSSWORD GAMES: A Ticket can only win one (1) time.

2.3 Procedure for Claiming Prizes.

A. To claim a "CROSSWORD" Scratch Ticket Game prize of $3.00, $5.00, $10.00, $15.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $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 "CROSSWORD" Scratch Ticket Game prize of $5,000 or $50,000, 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 "CROSSWORD" 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 "CROSSWORD" 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 "CROSSWORD" 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 35,040,000 Scratch Tickets in Scratch Ticket Game No. 2504. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2504 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$3.00	3,854,400	9.09
$5.00	1,962,240	17.86
$10.00	1,681,920	20.83
$15.00	490,560	71.43
$20.00	420,480	83.33
$50.00	140,160	250.00
$100	56,940	615.38
$500	2,920	12,000.00
$5,000	71	493,521.13
$50,000	18	1,946,666.67

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.07. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of Scratch Tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Scratch Ticket Game. The Executive Director may, at any time, announce a closing date (end date) for the Scratch Ticket Game No. 2504 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. 2504, 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-202304389
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 29, 2023

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Scratch Ticket Game Number 2550 "SHOW ME 100X"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2550 is "SHOW ME 100X". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2550 shall be $5.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2550.

A. Display Printing - That area of the Scratch Ticket outside of the area where the overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the Scratch Ticket.

C. Play Symbol - The printed data under the latex on the front of the Scratch Ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black Play Symbols are: 01, 02, 03, 04, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 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, 5X

SYMBOL, 10X SYMBOL, 100X SYMBOL, $5.00, $10.00, $20.00, $50.00, $100, $500, $1,000, $5,000 and $100,000.

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. 2550 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
02	TWO
03	THR
04	FOR
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI

30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
46	FRSX
47	FRSV
48	FRET
49	FRNI
50	FFTY
51	FFON
52	FFTO
53	FFTH
54	FFFR
55	FFFV
56	FFSX
57	FFSV
58	FFET

59	FFNI
60	SXTY
5X SYMBOL	WINX5
10X SYMBOL	WINX10
100X SYMBOL	WINX100
$5.00	FIV$
$10.00	TEN$
$20.00	TWY$
$50.00	FFTY$
$100	ONHN
$500	FVHN
$1,000	ONTH
$5,000	FVTH
$100,000	100TH

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 (2550), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 075 within each Pack. The format will be: 2550-0000001-001.

H. Pack - A Pack of the "SHOW ME 100X" 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 "SHOW ME 100X" Scratch Ticket Game No. 2550.

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 "SHOW ME 100X" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose sixty-seven (67) Play Symbols. GAME 1: If a player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "5X" Play Symbol, the player wins 5 TIMES the prize for that symbol. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. If the player reveals a "100X" Play Symbol, the player wins 100 TIMES the prize for that symbol. GAME 2: If a player matches any of the YOUR NUMBERS Play Symbols to either of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly sixty-seven (67) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly sixty-seven (67) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the sixty-seven (67) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the sixty-seven (67) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. GAME 1 (Ticket Front) - Key Number Match: A non-winning Prize Symbol will never match a winning Prize Symbol.

D. GAME 1 (Ticket Front) - Key Number Match: A Ticket may have up to three (3) matching non-winning Prize Symbols, unless restricted by other parameters, play action or prize structure.

E. GAME 1 (Ticket Front) - Key Number Match: There will be no matching non-winning YOUR NUMBERS Play Symbols on a Ticket.

F. GAME 1 (Ticket Front) - Key Number Match: There will be no matching WINNING NUMBERS Play Symbols on a Ticket.

G. GAME 1 (Ticket Front) - Key Number Match: The "5X" (WINX5) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

H. GAME 1 (Ticket Front) - Key Number Match: The "10X" (WINX10) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

I. GAME 1 (Ticket Front) - Key Number Match: The "100X" (WINX100) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

J. GAME 1 (Ticket Front) - Key Number Match: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 20 and $20).

K. GAME 2 (Ticket Back) - Key Number Match: A non-winning Prize Symbol will never match a winning Prize Symbol.

L. GAME 2 (Ticket Back) - Key Number Match: A Ticket may have up to two (2) matching non-winning Prize Symbols, unless restricted by other parameters, play action or prize structure.

M. GAME 2 (Ticket Back) - Key Number Match: There will be no matching non-winning YOUR NUMBERS Play Symbols on a Ticket.

N. GAME 2 (Ticket Back) - Key Number Match: There will be no matching WINNING NUMBERS Play Symbols on a Ticket.

O. GAME 2 (Ticket Back) - Key Number Match: No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 50 and $50).

P. GAME 2 (Ticket Back) - Key Number Match: No win(s) will appear in GAME 2 on the Ticket back, unless there is at least one (1) win in GAME 1 on the Ticket front.

2.3 Procedure for Claiming Prizes.

A. To claim a "SHOW ME 100X" Scratch Ticket Game prize of $5.00, $10.00, $20.00, $25.00, $50.00, $100 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $25.00, $50.00, $100 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery.

If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "SHOW ME 100X" Scratch Ticket Game prize of $1,000, $5,000 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 "SHOW ME 100X" 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 "SHOW ME 100X" 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 "SHOW ME 100X" Scratch Ticket Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Scratch Ticket Claim Period. All Scratch Ticket prizes must be claimed within 180 days following the end of the Scratch Ticket Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each Scratch Ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of Scratch Tickets ordered. The number of actual prizes available in a game may vary based on number of Scratch Tickets manufactured, testing, distribution, sales and number of prizes claimed. A Scratch Ticket Game may continue to be sold even when all the top prizes have been claimed.

3.0 Scratch Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of a Scratch Ticket in the space designated, a Scratch Ticket shall be owned by the physical possessor of said Scratch Ticket. When a signature is placed on the back of the Scratch Ticket in the space designated, the player whose signature appears in that area shall be the owner of the Scratch Ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the Scratch Ticket in the space designated. If more than one name appears on the back of the Scratch Ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Scratch Tickets and shall not be required to pay on a lost or stolen Scratch Ticket.

4.0 Number and Value of Scratch Prizes. There will be approximately 7,080,000 Scratch Tickets in Scratch Ticket Game No. 2550. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2550 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$5.00	731,600	9.68
$10.00	542,800	13.04
$20.00	94,400	75.00
$25.00	141,600	50.00
$50.00	94,400	75.00
$100	20,650	342.86
$500	3,540	2,000.00
$1,000	413	17,142.86
$5,000	10	708,000.00
$100,000	6	1,180,000.00

*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 4.35. 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. 2550 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. 2550, 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-202304390
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 29, 2023

♦ ♦ ♦

Scratch Ticket Game Number 2551 "MONEY MONEY MONEY"

1.0 Name and Style of Scratch Ticket Game.

A. The name of Scratch Ticket Game No. 2551 is "MONEY MONEY MONEY". The play style is "key number match".

1.1 Price of Scratch Ticket Game.

A. The price for Scratch Ticket Game No. 2551 shall be $10.00 per Scratch Ticket.

1.2 Definitions in Scratch Ticket Game No. 2551.

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, 03, 04, 06, 07, 08, 09, 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, 2X SYMBOL, 5X SYMBOL, 10X SYMBOL, $10.00,

$20.00, $30.00, $50.00, $100, $200, $500, $1,000, $10,000, $50,000 and $250,000.

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. 2551 - 1.2D

PLAY SYMBOL	CAPTION
01	ONE
03	THR
04	FOR
06	SIX
07	SVN
08	EGT
09	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY

31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
41	FRON
42	FRTO
43	FRTH
44	FRFR
45	FRFV
2X SYMBOL	DBL
5X SYMBOL	WINX5
10X SYMBOL	WINX10
$10.00	TEN$
$20.00	TWY$
$30.00	TRTY$
$50.00	FFTY$
$100	ONHN
$200	TOHN
$500	FVHN
$1,000	ONTH
$10,000	10TH
$50,000	50TH
$250,000	250TH

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 (2551), a seven (7) digit Pack number, and a three (3) digit Ticket number. Ticket numbers start with 001 and end with 050 within each Pack. The format will be: 2551-0000001-001.

H. Pack - A Pack of the "MONEY MONEY MONEY" Scratch Ticket Game contains 050 Tickets, packed in plastic shrink-wrapping and fan-folded in pages of one (1). Ticket back 001 and 050 will both be exposed.

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 "MONEY MONEY MONEY" Scratch Ticket Game No. 2551.

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 "MONEY MONEY MONEY" Scratch Ticket Game is determined once the latex on the Scratch Ticket is scratched off to expose sixty-two (62) Play Symbols. BONUS PLAY INSTRUCTIONS: If a player reveals 2 matching prize amounts in the same BONUS, the player wins that amount. MONEY MONEY MONEY PLAY INSTRUCTIONS: If the player matches any of the YOUR NUMBERS Play Symbols to any of the WINNING NUMBERS Play Symbols, the player wins the prize for that number. If the player reveals a "2X" Play Symbol, the player wins DOUBLE the prize for that symbol. If the player reveals a "5X" Play Symbol, the player wins 5 TIMES the prize for that symbol. If the player reveals a "10X" Play Symbol, the player wins 10 TIMES the prize for that symbol. No portion of the Display Printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Scratch Ticket.

2.1 Scratch Ticket Validation Requirements.

A. To be a valid Scratch Ticket, all of the following requirements must be met:

1. Exactly sixty-two (62) Play Symbols must appear under the Latex Overprint on the front portion of the Scratch Ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The Scratch Ticket shall be intact;

6. The Serial Number and Game-Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the Scratch Ticket;

8. The Scratch Ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The Scratch Ticket must not be counterfeit in whole or in part;

10. The Scratch Ticket must have been issued by the Texas Lottery in an authorized manner;

11. The Scratch Ticket must not have been stolen, nor appear on any list of omitted Scratch Tickets or non-activated Scratch Tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number and Game-Pack-Ticket Number must be right side up and not reversed in any manner;

13. The Scratch Ticket must be complete and not miscut, and have exactly sixty-two (62) Play Symbols under the Latex Overprint on the front portion of the Scratch Ticket, exactly one Serial Number and exactly one Game-Pack-Ticket Number on the Scratch Ticket;

14. The Serial Number of an apparent winning Scratch Ticket shall correspond with the Texas Lottery's Serial Numbers for winning Scratch Tickets, and a Scratch Ticket with that Serial Number shall not have been paid previously;

15. The Scratch Ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the sixty-two (62) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the sixty-two (62) Play Symbols on the Scratch Ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the Scratch Ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Game-Pack-Ticket Number must be printed in the Game-Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The Display Printing on the Scratch Ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The Scratch Ticket must have been received by the Texas Lottery by applicable deadlines.

B. The Scratch Ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Scratch Ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the Scratch Ticket. In the event a defective Scratch Ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective Scratch Ticket with another unplayed Scratch Ticket in that Scratch Ticket Game (or a Scratch Ticket of equivalent sales price from any other current Texas Lottery Scratch Ticket Game) or refund the retail sales price of the Scratch Ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. GENERAL: The top Prize Symbol will appear on every Ticket, unless restricted by other parameters, play action or prize structure.

B. GENERAL: Consecutive Non-Winning Tickets within a Pack will not have matching patterns, in the same order, of either Play Symbols or Prize Symbols.

C. BONUS: A non-winning Prize Symbol in one (1) BONUS play area will never match a winning Prize Symbol in another BONUS play area.

D. BONUS: A Ticket will not have matching non-winning Prize Symbols across the BONUS play areas.

E. BONUS: The $1,000, $10,000, $50,000 and $250,000 Prize Symbols will not be used in the BONUS play areas.

F. MONEY MONEY MONEY (Key Number Match): No prize amount in a non-winning spot will correspond with the YOUR NUMBERS Play Symbol (i.e., 20 and $20).

G. MONEY MONEY MONEY (Key Number Match): There will be no matching non-winning YOUR NUMBERS Play Symbols on a Ticket.

H. MONEY MONEY MONEY (Key Number Match): There will be no matching WINNING NUMBERS Play Symbols on a Ticket.

I. MONEY MONEY MONEY (Key Number Match): A non-winning Prize Symbol will never match a winning Prize Symbol.

J. MONEY MONEY MONEY (Key Number Match): A Ticket may have up to five (5) matching non-winning Prize Symbols, unless restricted by other parameters, play action or prize structure.

K. MONEY MONEY MONEY (Key Number Match): The "2X" (DBL) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

L. MONEY MONEY MONEY (Key Number Match): The "5X" (WINX5) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

M. MONEY MONEY MONEY (Key Number Match): The "10X" (WINX10) Play Symbol will only appear on winning Tickets, as dictated by the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "MONEY MONEY MONEY" Scratch Ticket Game prize of $10.00, $20.00, $30.00, $50.00, $100, $200 or $500, a claimant shall sign the back of the Scratch Ticket in the space designated on the Scratch Ticket and may present the winning Scratch Ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the Scratch Ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $30.00, $50.00, $100, $200 or $500 Scratch Ticket Game. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "MONEY MONEY MONEY" Scratch Ticket Game prize of $1,000, $10,000, $50,000 or $250,000, 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 "MONEY MONEY MONEY" 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 "MONEY MONEY MONEY" 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 "MONEY MONEY MONEY" 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 8,040,000 Scratch Tickets in Scratch Ticket Game No. 2551. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 2551 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in **
$10.00	964,800	8.33
$20.00	482,400	16.67
$30.00	321,600	25.00
$50.00	241,200	33.33
$100	80,400	100.00
$200	19,832	405.41
$500	2,680	3,000.00
$1,000	402	20,000.00
$10,000	8	1,005,000.00
$50,000	4	2,010,000.00
$250,000	5	1,608,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.80. 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. 2551 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. 2551, the State Lottery Act (Texas Government Code, Chap-

ter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-202304391
Bob Biard
General Counsel
Texas Lottery Commission
Filed: November 29, 2023

♦ ♦ ♦

North Central Texas Council of Governments

Request for Proposals for Bus Transportation Services for 2024 Wings Over Cowtown Air Show

The North Central Texas Council of Governments (NCTCOG) in partnership with the Fort Worth Naval Air Station Joint Reserve Base is seeking proposals from qualified, experienced, financially sound, and responsible Motor Coach Charter Bus Service providers to provide shuttle service from the remote parking lots at Ridgemar Mall for the April 13-14, 2024 "Wings over Cowtown Airshow". https://www.navymwrfortworth.com/event/airshow. NCTCOG is seeking estimates for 35-70 passenger buses (to be used on both days, 8:00 a.m. - 5:00 p.m.) and the availability of wheelchair accessible vehicles.

Proposals must be received no later than 5:00 p.m., Central Time, on **Friday, January 12, 2024,** to Gypsy Gavia, Principal Transportation Planner, North Central Texas Council of Governments, 616 Six Flags Drive, Arlington, Texas 76011 and electronic submissions to TransRFPs@nctcog.org. The Request for Proposals will be available at www.nctcog.org/rfp by the close of business on **Friday, December 8, 2023.**

NCTCOG encourages participation by disadvantaged business enterprises and does not discriminate on the basis of age, race, color, religion, sex, national origin, or disability.

TRD-202304397
R. Michael Eastland
Executive Director
North Central Texas Council of Governments
Filed: November 29, 2023

♦ ♦ ♦

Public Utility Commission of Texas

Notice of Application to Amend Designation as an Eligible Telecommunications Carrier

Notice is given to the public of an application filed with the Public Utility Commission of Texas on November 21, 2023, to amend a designation as an eligible telecommunications carrier (ETC) in the State of Texas under 47 U.S.C. § 214(e) and 16 Texas Administrative Code §26.418.

Docket Title and Number: Application of Sage Telecom Communications LLC dba Sage Wireless to Amend its Eligible Telecommunications Carrier Designation, Docket Number 55870.

The Application: Sage Telecom Communications LLC dba Sage Wireless requests that its ETC designation be amended to expand its service area to include additional wire centers for Lifeline purposes only.

Persons who wish to file a motion to intervene or comments on the application should contact the commission no later than December 28, 2023, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or 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 55870.

TRD-202304386
Andrea Gonzalez
Rules Coordinator
Public Utility Commission of Texas
Filed: November 29, 2023

♦ ♦ ♦

Supreme Court of Texas

Order Approving Education Rules on Guardianship, Alternatives to Guardianship, and Supports and Services for Proposed Wards and Wards

Supreme Court of Texas

Misc. Docket No. 23-9097

Order Approving Education Rules on Guardianship, Alternatives to Guardianship, and Supports and Services for Proposed Wards and Wards

ORDERED that:

1. In accordance with the Act of May 27, 2023, 88th Leg., R.S. ch. 939 (S.B. 1624, codified at TEX. GOV'T CODE § 22.0133 and TEX. EST. CODE § 1054.157), the Court approves the following Education Rules on Guardianship, Alternatives to Guardianship, and Supports and Services for Proposed Wards and Wards, effective immediately.

2. The Clerk is directed to:

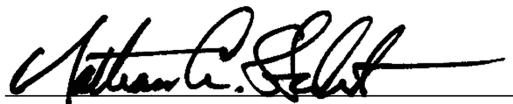
   a. file a copy of this Order with the Secretary of State;

   b. cause a copy of this Order to be mailed to each registered member of the State Bar of Texas by publication in the *Texas Bar Journal*;

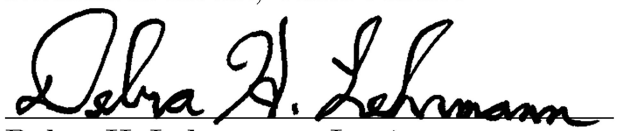
   c. send a copy of this Order to each elected member of the Legislature; and

   d. submit a copy of this Order for publication in the *Texas Register*.

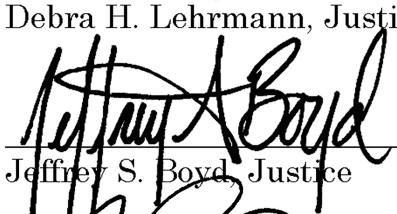
Dated: November 29, 2023.



Nathan L. Hecht, Chief Justice

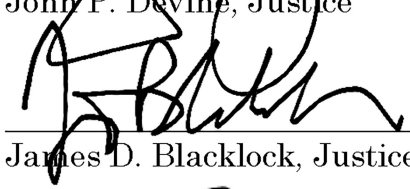


Debra H. Lehrmann, Justice

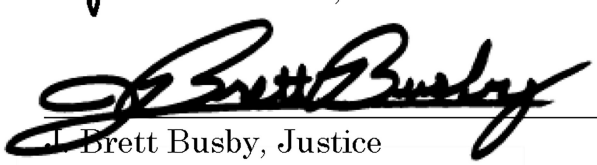


Jeffrey S. Boyd, Justice

John P. Devine, Justice



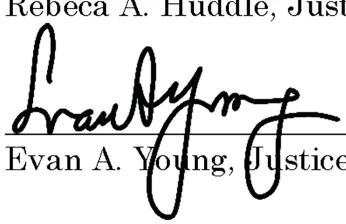
James D. Blacklock, Justice



J. Brett Busby, Justice

Jane N. Bland, Justice

Rebeca A. Huddle, Justice



Evan A. Young, Justice

Education Rules on Guardianship, Alternatives to Guardianship, and Supports and Services for Proposed Wards and Wards

Rule 1. Authority

These rules are adopted pursuant to Section 22.0133 of the Government Code and Section 1054.157 of the Estates Code.

Rule 2. Definitions

In these rules:

(a) "Alternatives to guardianship" has the same meaning as is assigned in Section 1002.0015 of the Estates Code.

(b) "Court investigator" means a person appointed under Subchapter D of Chapter 1054 of the Estates Code.

(c) "Court visitor" means a person appointed to conduct evaluations of wards and file reports with the court under Subchapter C of Chapter 1054 of the Estates Code.

(d) "Probate judge" means a constitutional county court judge, statutory county court judge, statutory probate judge, or any associate judge who has jurisdiction over guardianship.

(e) "Proposed ward" means a person for whom an application for the appointment of a guardian has been filed but who is not under guardianship.

(f) "Supports and services" has the same meaning as is assigned in Section 1002.031 of the Estates Code.

(g) "Ward" means a person under guardianship.

Rule 3. Biennial Education

(a) *Probate Judge.*

(1) A probate judge who was in office on September 1, 2023, must complete:

(A) one hour of education on alternatives to guardianship and supports and services available to proposed wards and wards by December 1, 2025; and

(B) one hour of education on alternatives to guardianship and supports and services available to proposed wards and wards every two years thereafter.

(2) A probate judge who assumes office after September 1, 2023, must complete one hour of education on alternatives to guardianship and supports and services available to proposed wards and wards every two years from the probate judge's anniversary of assuming office.

(3) The probate judge must certify completion consistent with Rule 9 of the Rules of Judicial Education.

(b) *Court Investigator or Court Visitor.*

(1) A court investigator or a court visitor must complete two hours of education on guardianship every two years. Of the two hours of education, the court investigator or the court visitor must complete one hour of education on alternatives to guardianship and supports and services available to proposed wards and wards.

(2) Certification. The court investigator and the court visitor must file with each appointing court a certificate or other proof of completion.

(c) *Other Laws and Rules Applicable.* Nothing in this rule excuses completion of other education requirements mandated by law or rule.

Rule 4. Approved Programs

(a) Programs sponsored by the following organizations may be used to satisfy the education requirements of these rules:

(1) programs listed in Rule 2(c) of the Rules of Judicial Education; and

(2) any other program approved by the Supreme Court, in consultation with the Court of Criminal Appeals and the Judicial Branch Certification Commission.

(b) A provider of a continuing education program, a probate judge, a court investigator, or a court visitor may request approval of a program under (a)(2). The request must be accompanied by an outline of the materials that describe the course content, identify the presenters, indicate the time allotted to each segment, and provide the date and location of the program.

TRD-202304381
Jaclyn Daumerie
Rules Attorney
Supreme Court of Texas
Filed: November 29, 2023

♦ ♦ ♦

Renewed Emergency Order Regarding Indigent Defense and the Border Security State of Disaster Permitting Out-of-State Lawyers to Practice in Texas Temporarily

Supreme Court of Texas

Misc. Docket No. 23-9096

Renewed Emergency Order Regarding Indigent Defense and the Border Security State of Disaster Permitting Out-of-State Lawyers to Practice in Texas Temporarily

ORDERED that:

1. The Court's Renewed Emergency Order Regarding Indigent Defense and the Border Security State of Disaster Permitting Out-of-State Lawyers to Practice in Texas Temporarily, Misc. Dkt. No. 22-9105, is renewed as amended.

2. To protect the constitutionally and statutorily guaranteed right to counsel of indigent criminal defendants, and pursuant to Section 81.061 of the Texas Government Code, and notwithstanding Chapter 81, Subchapter G, an attorney who is licensed to practice law in another U.S. jurisdiction and who meets the following criteria is permitted to practice law in Texas:

a. the attorney is in good standing and authorized to practice law with the entity that governs the practice of law in the jurisdiction in which the attorney is licensed;

b. the attorney agrees to abide by the Texas Disciplinary Rules of Professional Conduct and to submit to the disciplinary jurisdiction of the Supreme Court of Texas and the State Bar of Texas;

c. the attorney is providing services as an employee of a public defender office or through a managed assigned counsel program to indigent defendants arrested for misdemeanor offenses under Operation Lone Star launched by Governor Abbott on March 6, 2021, and is on the alternative appointment list established by the Texas Indigent Defense Counsel or its designee under Renewed Emergency Order Regarding Indigent Defense and Border Security State of Disaster, Misc. Dkt. No. 23-9086, or prior or subsequent renewal orders;

d. the attorney registers to provide services at www.texasbar.com/SCOTEO229007 before providing services under this Order; and

e. by March 1, 2024 or within 90 days after registering under (d), whichever is later, the attorney applies with the Texas Board of Law Examiners to be admitted to practice law in Texas.

3. This Order expires on December 1, 2024, unless extended by the Chief Justice of the Supreme Court. But an attorney may complete after December 1, 2024, any ongoing services commenced before December 1, 2024.

4. The Clerk of the Supreme Court is directed to:

a. post a copy of this Order on www.txcourts.gov;

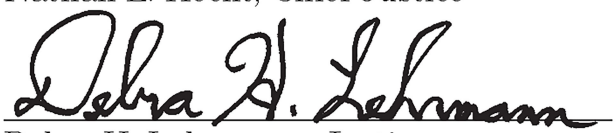
b. file a copy of this Order with the Secretary of State; and

c. send a copy of this Order to the Governor, the Attorney General, and each member of the Legislature.

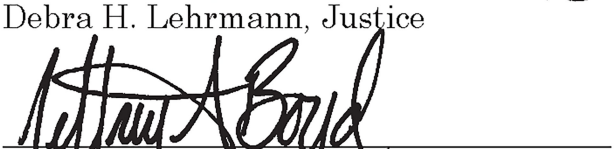
5. The State Bar of Texas is directed to take all reasonable steps to notify members of the Texas bar of this Order and to create and maintain the website for attorneys to register under this Order.

Dated: November 17, 2023.

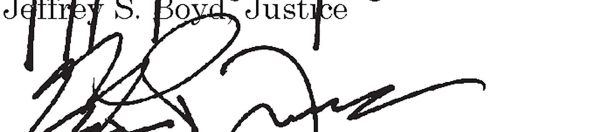
Nathan L. Hecht, Chief Justice



Debra H. Lehrmann, Justice



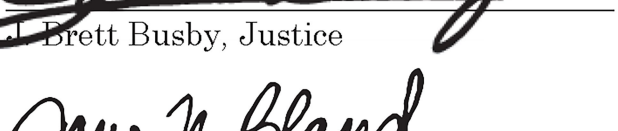
Jeffrey S. Boyd, Justice



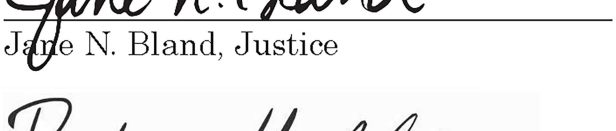
John P. Devine, Justice

James D. Blacklock, Justice

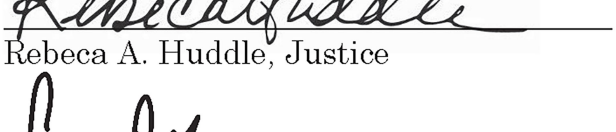
J. Brett Busby, Justice



Jane N. Bland, Justice



Rebeca A. Huddle, Justice



Evan A. Young, Justice

TRD-202304331
Jaclyn Daumerie
Rules Attorney
Supreme Court of Texas
Filed: November 20, 2023

♦ ♦ ♦

Teacher Retirement System of Texas

Report of Fiscal Transactions, Accumulated Cash and Securities, and Rate of Return on Assets and Actuary's Certification of Actuarial Valuation and Actuarial Present Value of Future Benefits

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," this document is not

included in the print version of the Texas Register. The document is available in the on-line version of the December 8, 2023, issue of the Texas Register.)

TRD-202304370
Brian Guthrie
Executive Director
Teacher Retirement System of Texas
Filed: November 27, 2023

♦ ♦ ♦


TEXAS

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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