TEXAS REGISTER

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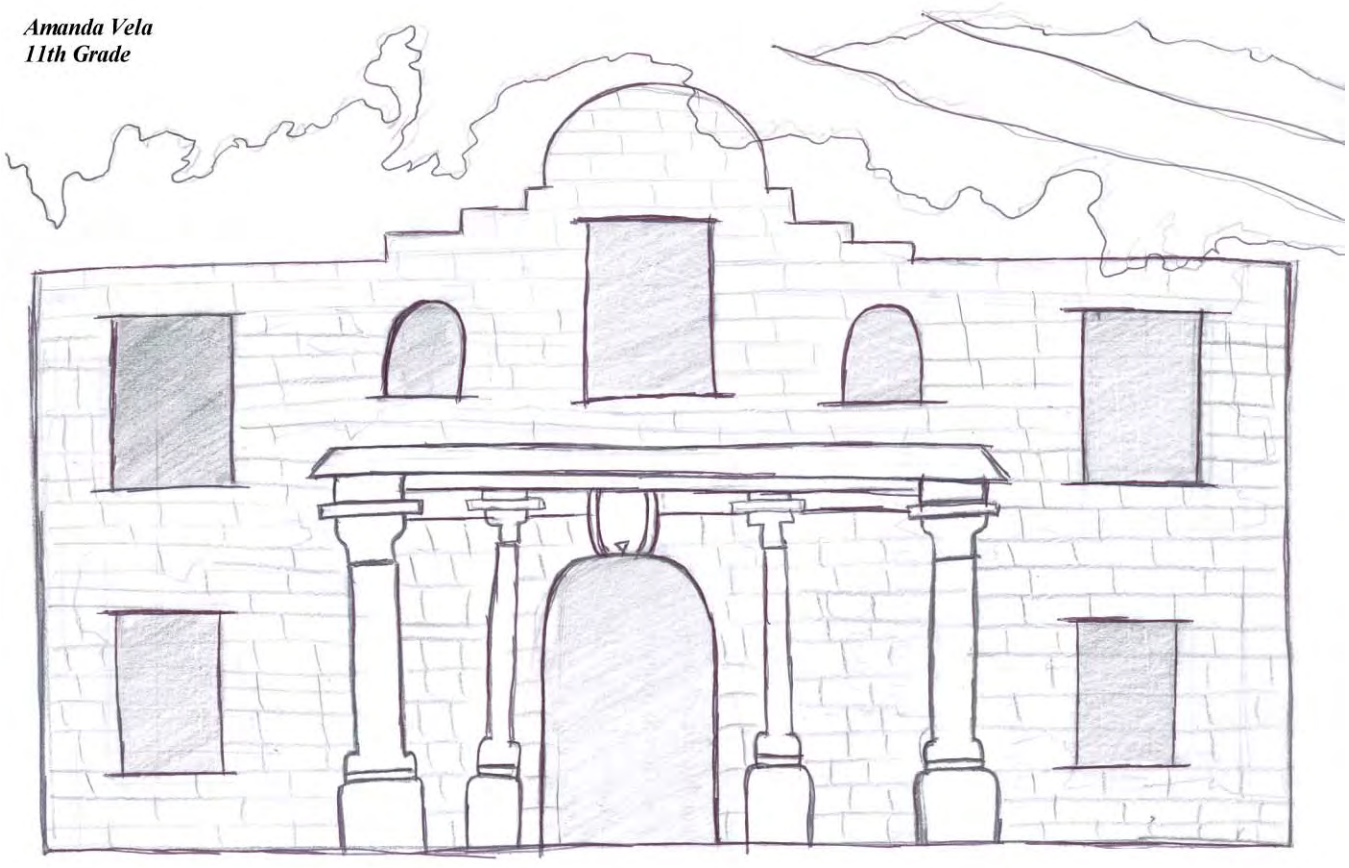

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but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

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

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IN THIS ISSUE

THE GOVERNOR

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

Appointments

Appointments for March 22, 2011

Designating D. Joseph Meister as presiding officer of the Texas Public Finance Authority for a term at the pleasure of the Governor. Mr. Meister is replacing Gary Wood of Lakeway as presiding officer.

Appointments for April 6, 2011

Appointed to the Texas Emerging Technology Advisory Committee for a term to expire August 31, 2012, Ofer Molad of Bellaire (replacing Michael Bleyzer of Houston whose term expired).

Designating Thomas Butler as presiding officer of the Credit Union Commission for a term at the pleasure of the Governor. Mr. Butler is replacing Gary Janacek of Belton as presiding officer.

Appointments for April 11, 2011

Appointed to the Texas Violent Gang Task Force for a term at the pleasure of the Governor, Rene M. Pena of Floresville (replacing Geoffrey Barr of New Braunfels who resigned).

Appointed to the Radiation Advisory Board for a term to expire April 16, 2015, Kenneth V. Krieger of Lacy Lakeview (replacing Lawrence Jacobi, Jr. of Austin who resigned).

Rick Perry, Governor

TRD-201101393

♦ ♦ ♦

EMERGENCY RULES

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

TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER F. PHARMACEUTICAL BENEFITS

28 TAC §134.503

The Texas Department of Insurance, Division of Workers' Compensation is renewing the effectiveness of the emergency adoption of amended §134.503, for a 60-day period. The text of the amended section was originally published in the December 31, 2010, issue of the *Texas Register* (35 TexReg 11775).

Filed with the Office of the Secretary of State on April 11, 2011.

TRD-201101361
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Original Effective Date: January 1, 2011
Expiration Date: June 29, 2011
For further information, please call: (512) 804-4706

♦ ♦ ♦

PROPOSED RULES

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

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §§355.101 - 355.103, 355.105 - 355.107, 355.110

The Texas Health and Human Services Commission (HHSC) proposes to amend §355.101, concerning Introduction; §355.102, concerning General Principles of Allowable and Unallowable Costs; §355.103, concerning Specifications for Allowable and Unallowable Costs; §355.105, concerning General Reporting and Documentation Requirements, Methods, and Procedures; §355.106, concerning Basic Objectives and Criteria for Audit and Desk Review of Cost Reports; §355.107, concerning Notification of Exclusions and Adjustments; and §355.110, concerning Informal Reviews and Formal Appeals.

Background and Justification

Sections 355.101 through 355.111 in Subchapter A detail the cost determination process for nursing facilities, intermediate care facilities for persons with mental retardation and community-based programs where HHSC is responsible for calculating recommended reimbursements. HHSC is amending Subchapter A to: 1) incorporate the School Health and Related Services program; 2) accommodate the utilization of a web-based cost reporting system; 3) formalize certain existing practices; 4) standardize the cost at which a purchase must be depreciated; 5) allow for the reporting of certain costs associated with workers' compensation; and 6) specify the repercussions of submitting an incomplete request for an informal review.

Incorporation of the School Health and Related Services (SHARS) Program

HHSC is amending Subchapter A to incorporate the SHARS program. Reimbursements for the SHARS program are based on cost-report data but SHARS is not currently addressed in Subchapter A. Incorporation of SHARS into Subchapter A will make cost-reporting requirements consistent across all community-based programs for which HHSC determines payment rates. Where differences in cost determination processes specific to SHARS exist, they will be noted in Subchapter A.

Accommodation of Web-Based Cost Reporting

HHSC is in the early stages of rolling out a web-based cost-reporting system (the State of Texas Automated Information Reporting System or STAIRS) to replace its existing cost reporting system and is proposing to amend Subchapter A to accommodate both the current cost-reporting system and this new system. Features of STAIRS and associated proposed amendments include the following:

STAIRS will be able to limit access to the data entry portion of the application to individuals who have completed the required cost-report trainings. This feature will make the requirement that cost-report training certificates be submitted with each cost report obsolete. In response to this feature, HHSC proposes to eliminate the requirement that cost-report training certificates be submitted with cost reports completed through STAIRS.

STAIRS will be able to accept electronic signatures, which could make obsolete the requirement that signed and notarized cost-report certifications be submitted with each cost report. HHSC proposes to allow electronic signatures on cost-report certifications when such signatures are specifically allowed under HHSC policies and procedures.

Finally, STAIRS will enable HHSC to notify providers of exclusions and adjustments made to their reported expenses via e-mail. In response to this feature, HHSC proposes to allow notices of exclusions and adjustments to be made either via e-mail or United States mail rather than limiting such notices to United States mail, as is the case under the current rule language.

Formalizing Existing Practices

Section 355.102 details general principles of allowable and unallowable costs. HHSC proposes to amend this section to formalize the requirement that health and life insurance premiums and other employee benefits be direct costed.

Section 355.110 details requirements for submitting a request for an informal review. HHSC proposes to amend this section to formalize the requirement that additional information submitted by a provider be submitted by hand delivery, United States mail, or special mail delivery. As well, HHSC proposes to eliminate a reference to an informal review panel because informal reviews are not considered by panels but rather by individual HHSC staff.

Standardizing the Cost at Which a Purchase Must be Depreciated

Current language in §355.103 requires providers to depreciate items costing more than $2,500 except for extraordinary repairs, which must be depreciated if they cost more than $1,000. HHSC proposes to standardize when providers are required to depreciate items by amending this section to require extraordinary repairs to be depreciated if they cost more than $2,500.

Allowing for the Reporting of Certain Costs Associated with Workers' Compensation

Section 355.103 details specific allowable and unallowable costs. HHSC proposes to amend this section to allow for

reporting the part of a workers' compensation litigation award or settlement that reimburses the injured employee for lost wages and medical bills on a cost report as an allowable cost. Workers' compensation benefits are already allowable costs and since these newly allowable costs will accrue as benefits to the employee, this proposal is consistent with current policy.

Repercussions of Submitting an Incomplete Request for an Informal Review

Current language in §355.110 requires that an interested party must, with its request for an informal review, submit a concise statement of the specific actions or determinations it disputes, its recommended resolution, and any supporting documentation the interested party deems relevant to the dispute. This rule language does not indicate the repercussions of failing to meet this requirement. HHSC proposes to amend this section to indicate that a request for an informal review that does not meet the requirements detailed in the rule will not be accepted.

Section-by-Section Summary

The proposed amendments to §355.101 are as follows:

Revise subsection (a) to incorporate the SHARS program.

Add a new paragraph (4) to subsection (b) which defines the terms "Texas Education Agency" and "TEA."

The proposed amendments to §355.102 are as follows:

Revise subsection (b) to add a closing parenthesis at the end of the subsection.

Revise subsection (d) to replace a reference to preparers' signing the Cost Report Methodology Certification with a generic reference to cost report preparers and to exempt cost reports submitted through the State of Texas Automated Information and Reporting System (STAIRS) from the requirement that a cost-report training certificate be submitted with each cost report.

Modify subsection (d)(1) by creating two subparagraphs (A) and (B). Subparagraph (A) incorporates a requirement that new cost report preparers for the SHARS program must complete state-sponsored online cost-report training while subparagraph (B) contains the original contents of paragraph (1) but limits their applicability to all programs except SHARS.

Add a new subsection (d)(4) to indicate that the failure of a SHARS provider to comply with the requirements of subsection (d) may result in an administrative contract violation as specified in Title 1 of the Texas Administrative Code (TAC) §355.8443 (relating to Reimbursement Methodology for School Health and Related Services (SHARS)) and re-number the subsequent paragraph.

Modify subsection (f)(4) to indicate that for SHARS providers, an unrestricted indirect cost rate is utilized.

Add a new paragraph (3) in subsection (g) to indicate that placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may result in an administrative contract violation for a SHARS provider and re-number the subsequent paragraph.

Add a new paragraph (3) in subsection (h) to indicate that inaccuracy in providing, or failure to provide, required financial and statistical data may result in an administrative contract violation for a SHARS provider, and re-number the subsequent paragraph.

Modify subsection (j) to indicate that health insurance premiums, life insurance premiums and other employee benefits must be direct costed.

Add a new subsection (j)(1)(D)(iii)(III) to indicate that failure to use an approved or required allocation method may result in an administrative contract violation for a SHARS provider, and re-number the subsequent subclause.

The proposed amendment to §355.103 is as follows:

Modify subsection (b)(6)(B) to indicate that extraordinary repairs costing $2,500 or more, with a useful life in excess of one year, should be capitalized and depreciated.

Modify subsection (b)(17)(I) to indicate that, for workers' compensation litigation awards and settlements, the part of the award or settlement that reimburses the injured employee for lost wages and medical bills is an allowable cost.

The proposed amendments to §355.105 are as follows:

Modify subsection (b)(4)(A)(ii) to allow for electronic signatures on cost-report certifications when such signatures are specifically allowed under HHSC policies and procedures.

Modify subsection (b)(4)(A)(vii) to exempt cost reports submitted through STAIRS from the requirement to include a copy of the state-issued cost report training certificate.

Add a new subsection (b)(4)(B)(ii) to indicate that placement on a cost report of an amount which was determined to be inaccurately placed may result in an administrative contract violation for a SHARS provider, and re-number the subsequent clause.

Add a new subsection (b)(4)(C)(ii) to indicate that failure to file a completed cost report by the cost report due date constitutes an administrative contract violation for a SHARS provider, and re-number the subsequent clause.

Modify paragraph (1) in subsection (c) to indicate that SHARS providers must submit cost reports to HHSC Rate Analysis as specified in 1 TAC §355.8443.

Add a new paragraph (2) in subsection (f) to indicate that failure to reimburse HHSC for the cost of an out-of-state audit within 60 days of the request for payment constitutes an administrative contract violation for a SHARS provider, and re-number the subsequent paragraph.

Modify subsection (i)(4)(A) to update the titles of cross-referenced sections.

The proposed amendments to §355.106 are as follows:

In subsection (a), add a new paragraph (3) to indicate that failure by a SHARS provider to complete cost reports according to instructions and rules may result in an administrative contract violation, and re-number the subsequent paragraph.

In subsection (f), add a new paragraph (3) to indicate that failure by a SHARS provider to allow access to any and all records necessary to verify information submitted on a cost report may result in an administrative contract amendment, and re-number the subsequent paragraph.

The proposed amendment to §355.107 is as follows:

Modify subsection (a) to indicate that notice to providers of exclusions and adjustments to reported expenses on a cost report consists of either a letter to the provider or an e-mail notification.

The proposed amendments to §355.110 are as follows:

Modify subsection (a)(1)(C) to replace a reference to a Texas Department of Aging and Disability Services (DADS) contracted provider with a reference to an HHSC Enterprise contracted or enrolled provider.

Modify subsection (c)(1)(B) to indicate that if the requirements of the subparagraph are not met, the request for an informal review will not be accepted.

Modify subsection (c)(1)(C) to replace a reference to the applicable DADS Form 2031 with a reference to the applicable HHSC Enterprise or Texas Medicaid and Healthcare Partnership signature authority designation form.

Modify subsection (c)(2)(A) to require that additional information must be received in writing by hand delivery, United States (U.S.) mail, or special mail delivery and to replace a reference to the panel's written decision with a reference to the informal review written decision.

Fiscal Note

Gordon E. Taylor, Chief Financial Officer for the Department of Aging and Disability Services, has determined that during the first five-year period the amended rules are in effect there will be no fiscal impact to state government. While allowing certain lawsuit settlement amounts pertaining to workers' compensation claims to be reported on cost reports and increasing the cost at which an extraordinary repair is required to be depreciated will increase the cost base used in determining payment rates, the increase is not expected to be significant. As well, since payment rates are constrained by appropriations, it is not expected that the small increase in the cost base will have any impact on actual payment rates. The amended rules will not result in any fiscal implications for local health and human services agencies. There are no fiscal implications for local governments as a result of enforcing or administering the sections.

Small Business and Micro-business Impact Analysis

Carolyn Pratt, Director of Rate Analysis, has determined that there is no adverse economic effect on small businesses or micro-businesses as a result of enforcing or administering the amendments. The implementation of the proposed rule amendments does not require any changes in practice or any additional cost to the contracted provider.

HHSC does not anticipate that there will be any economic cost to persons who are required to comply with these amendments. The amendments will not affect local employment.

Public Benefit

Carolyn Pratt also has determined that for each of the first five years the amendments are in effect, the expected public benefits are: 1) that the rules will provide clear guidance to agency staff and providers on requirements pertaining to SHARS cost determination, reporting of health and life insurance and other employee benefits, and the filing and processing of informal reviews; 2) the rules will provide needed flexibility to implement a new, web-based cost reporting system; 3) the cost at which providers are required to depreciate items will be standardized throughout the cost determination rules; and 4) additional expenses related to reimbursing injured employees for lost wages and medical bills will be recognized in the cost report databases HHSC uses to determine reimbursement rates.

Takings Impact Assessment

HHSC has determined that this 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.

Regulatory Analysis

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

Public Comment

Questions about the content of this proposal may be directed to Pam McDonald in the HHSC Rate Analysis Department by telephone at (512) 491-1373. Written comments on the proposal may be submitted to Ms. McDonald by fax to (512) 491-1998; by e-mail to pam.mcdonald@hhsc.state.tx.us; or by mail to HHSC Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas, 78708-5200, within 30 days of publication of this proposal in the *Texas Register.*

Statutory Authority

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

The amendments affect Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32. No other statutes, articles, or codes are affected by this proposal.

§355.101. Introduction.

(a) The information in §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this title (relating to Revenues), and §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) applies to Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, School Health and Related Services, and Texas Home Living programs cost reports pertaining to providers' fiscal years ending in calendar year 2004 and subsequent years. For all other programs these sections apply to cost reports pertaining to the providers' fiscal years ending in calendar year 1997 and subsequent years.

(b) The following terms, when used in [~~terminology applies to the state agencies referenced in~~] this subchapter, have the following meanings:

(1) HHSC--The [~~Whenever the terms "Texas Health and Human Services Commission" or "HHSC" occur, they each mean the~~] Texas Health and Human Services Commission [~~or its designee~~].

(2) DHS--The [~~Whenever the terms "Texas Department of Human Services" or "DHS" occur, they each mean the~~] Texas Department of Human Services or its successor agency.

(3) TDMHMR--The [~~Whenever the terms "Texas Department of Mental Health and Mental Retardation" or "TDMHMR" occur, they each mean the~~] Texas Department of Mental Health and Mental Retardation or its successor agency.

(4) TEA--The Texas Education Agency or its successor agency.

(c) HHSC [~~The Texas Health and Human Services Commission (HHSC)~~] reimburses providers for contracted client services through reimbursement amounts determined as described in this chapter and in reimbursement methodologies for each program. Statewide, uniform reimbursements[~~,~~] and reimbursement ceilings are approved by HHSC. Where reimbursements are contractor-specific, HHSC approves the reimbursement parameter dollar amounts, e.g., ceilings, floors, or program reimbursement formula limits. In approving reimbursement amounts HHSC takes into consideration staff recommendations based on the application of formulas and procedures described in this chapter and in reimbursement methodologies for each program. However, HHSC may adjust staff recommendations when HHSC deems such adjustments are warranted by particular circumstances likely to affect achievement of program objectives, including economic conditions and budgetary considerations. Methodology rules are developed and recommended for approval to HHSC. HHSC has oversight authority with respect to the state's reimbursement methodology and cost determination rules.

(1) Reimbursement amounts will be determined coincident with the state's biennium.

(2) Objective of cost determination process. The objective of the cost determination process is to define direct and indirect costs that are allowable and, therefore, may be considered for use in the overall reimbursement determination process. The cost determination process seeks to collect accurate financial and other statistical data that constitutes the foundation upon which reimbursements are determined.

(A) Cost-reporting. In order to ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires that each contracted provider submit a periodic cost report or supplemental report. It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent HHSC cost reporting rules and cost report instructions, on the cost report and any supplemental reports required by HHSC.

(B) Pro forma costing. When historical costs are unavailable, such as in the case of a new program, reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

(3) Relationship between cost determination and reimbursement determination processes. The cost determination process seeks to evaluate individual cost items of providers to determine their allowability and to determine whether individual cost reports are of reasonable accuracy for potential use in reimbursement determination. The reimbursement determination process takes the evaluation of allowable costs one step further by comparing allowable costs across providers to identify those levels of cost, either for individual cost items or groups of cost items, which must be incurred by efficient and economic providers of services meeting all state and federal standards. Thus, all costs allowed in the cost determination process may not necessarily be used in the reimbursement determination process. The basic objective of the reimbursement methodologies employed by HHSC is to facilitate and balance the broader objectives of the programs administered by the agencies by:

(A) promoting reasonable access for eligible clients to services that meet federal and state quality standards via contracting with an adequate number of qualified providers; and

(B) expending taxpayer dollars in a reasonable and prudent manner such that eligible clients are served at the lowest cost to taxpayers consistent with state and federal laws, standards and regulations, and with program objectives.

§355.102. General Principles of Allowable and Unallowable Costs.

(a) Allowable and unallowable costs. Allowable and unallowable costs, both direct and indirect, are defined to identify expenses that are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations. When a particular type of expense is classified as unallowable, the classification means only that the expense will not be included in the database for reimbursement determination purposes because the expense is not considered reasonable and/or necessary. The classification does not mean that individual contracted providers may not make the expenditure. The description of allowable and unallowable costs is designed to be a general guide and to clarify certain key expense areas. This description is not comprehensive, and the failure to identify a particular cost does not necessarily mean that the cost is an allowable or unallowable cost.

(b) Cost-reporting process. The primary objective of the cost-reporting process is to provide a basis for determining appropriate reimbursement to contracted providers. To achieve this objective, the reimbursement determination process uses allowable cost information reported on cost reports or other surveys. The cost report collects actual allowable costs and other financial and statistical information, as required. Costs may not be imputed and reported on the cost report when no costs were actually incurred (except as stated in §355.103(b)(16)(A)(i) of this title (relating to Specifications for Allowable and Unallowable Costs) or when documentation does not exist for costs even if they were actually incurred during the reporting period).

(c) Accurate cost reporting. Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs incurred, based on an accrual method of accounting, which are reasonable and necessary, in accordance with allowable and unallowable cost guidelines in this section and in §355.103 of this title, revenue reporting guidelines in §355.104 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. The Texas Health and Human Services Commission (HHSC) is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(d) Cost report training. It is the responsibility of the provider to ensure that each cost report preparer [~~signing the Cost Report Methodology Certification~~] has completed the required state-sponsored cost report training. Preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of

cost report preparation. Preparers must complete cost report training for each program for which a cost report is submitted. Preparers must complete cost report training every other year for the odd-year cost report in order to receive a certificate to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive a certificate to complete the even-year cost report, he/she must complete an even-year cost report training. A copy of the most recent cost report training certificate for each preparer of the cost report must be submitted with each cost report, except for cost reports submitted through the State of Texas Automated Information and Reporting System (STAIRS). Contracted preparer's fees to complete state-sponsored cost report training are allowable.

(1) New preparers. Preparers, who have not previously completed the required state-sponsored cost report training and received a completion certificate, must complete the state-sponsored cost report training as follows: [attend state-sponsored classroom-based cost report training for each contracted program for which a cost report is to be submitted. Travel costs associated with completing the state-sponsored cost report training are allowable within the travel limits specified in §355.103(b)(12) of this title.]

(A) For School Health and Related Services (SHARS) providers, new preparers must complete state-sponsored online cost report training and receive a certificate of completion. Failure to complete the required training may result in an administrative contract violation as specified in §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)). Applicable federal and state accessibility standards apply to online training.

(B) For all other programs, new preparers must attend state-sponsored classroom-based cost report training for each contracted program for which a cost report is to be submitted. Travel costs associated with completing the state-sponsored cost report training are allowable within the travel limits specified in §355.103(b)(12) of this title.

(2) All other preparers. Preparers who are not new preparers as defined in paragraph (1) of this subsection must complete state-sponsored online cost report training and receive a certificate of completion for each program for which a cost report is submitted. These preparers must receive their cost report training online and do not have the option of receiving completion certificates through classroom-based training. Preparers that participate in online training will be assessed a convenience fee, which will be determined by HHSC. Convenience fees assessed for state-sponsored online cost report training are allowable costs. Applicable federal and state accessibility standards apply to online training.

(3) For nursing facilities, failure to file a completed cost report signed by preparers who have completed the required cost report training may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(4) For SHARS providers, failure to complete the required cost report training may result in an administrative contract violation as specified in §355.8443 of this title.

(5) [~~(4)~~] For all other programs, failure to file a completed cost report signed by preparers who have completed the required cost report training constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

(e) Generally accepted accounting principles. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost reporting rules differ from GAAP, IRS, or other authorities, HHSC rules take precedence for provider cost-reporting purposes.

(f) Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs (1) and (2) of this subsection, and which meet the requirements as specified in subsections (i), (j), and (k) of this section, in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(1) "Reasonable" refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service. In determining the reasonableness of a given cost, the following are considered:

(A) the restraints or requirements imposed by arm's-length bargaining, i.e., transactions with nonowners or other unrelated parties, federal and state laws and regulations, and contract terms and specifications; and

(B) the action that a prudent person would take in similar circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, and members, and the fulfillment of the purpose for which the business was organized.

(2) "Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted client care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing client care in accordance with the contract and state and federal regulations. In addition, to qualify as a necessary expense, a direct or indirect cost must meet all of the following requirements:

(A) the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;

(B) the cost does not appear as a specific unallowable cost in §355.103 of this title;

(C) if a direct cost, it bears a significant relationship to contracted client care. To qualify as significant, the elimination of the expenditure would have an adverse impact on client health, safety, or general well-being;

(D) the direct or indirect expense was incurred in the purchase of materials, supplies, or services provided to clients or staff in the normal conduct of operations to provide contracted client care;

(E) the direct or indirect costs are not allocable to or included as a cost of any other program in either the current, a prior, or a future cost-reporting period;

(F) the costs are net of all applicable credits;

(G) allocated costs of each program are adequately substantiated; and

(H) the costs are not prohibited under other pertinent federal, state, or local laws or regulations.

(3) Direct costs are those costs incurred by a provider that are definitely attributable to the operation of providing contracted client services. Direct costs include, but are not limited to, salaries and nonlabor costs necessary for the provision of contracted client care. Whether or not a cost is considered a direct cost depends upon the specific contracted client services covered by the program. In programs in which client meals are covered program services, the salaries of cooks and other food service personnel are direct costs, as are food, nonfood supplies, and other such dietary costs. In programs in which client transportation is a covered program service, the salaries of drivers are direct costs, as are vehicle repairs and maintenance, vehicle insurance and depreciation, and other such client transportation costs.

(4) Indirect costs are those costs that benefit, or contribute to, the operation of providing contracted services, other business components, or the overall contracted entity. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office [~~and/~~]or home office administrative expenses are considered indirect costs. As specified in §355.8443 of this title, SHARS providers use an unrestricted indirect cost rate to determine indirect costs.

(g) Unallowable costs. Unallowable costs are expenses that are not reasonable or necessary, according to the criteria specified in subsection (f)(1) - (2) of this section and which do not meet the requirements as specified in subsections (i), (j), and (k) of this section or which are specifically enumerated in §355.103 of this title or program-specific reimbursement methodology. Providers must not report as an allowable cost on a cost report a cost that has been determined to be unallowable. Such reporting may constitute fraud. (Refer to §355.106(a) of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports)).

(1) For nursing facilities, placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may result in vendor hold as specified in §355.403 of this title.

(2) For Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, placement as an allowable cost on a cost report a cost, which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS providers, submission of a cost that has been determined to be unallowable may result in an administrative contract violation as specified in §355.8443 of this title.

(4) [~~(3)~~] For all other programs, submission of a [~~placement as an allowable~~] cost [~~on a cost report of a cost~~], which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(h) Other financial and statistical data. The primary purpose of the cost report is to collect allowable costs to be used as a basis for reimbursement determination. In addition, providers may be required on cost reports to provide information in addition to allowable costs to support allowable costs, such as wage surveys, workers' compensation surveys, or other statistical and financial information. Additional data requested may include, when specified and in the appropriate section or line number specified, costs incurred by the provider which are unallowable costs. All information, including other financial and statistical data, shown on a cost report is subject to the documentation and verification procedures required for an audit desk review and/or field audit.

(1) For nursing facilities, inaccuracy in providing, or failure to provide, required financial and statistical data may result in vendor hold as specified in §355.403 of this title.

(2) For Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS, inaccuracy in providing, or failure to provide, required financial and statistical data may result in an administrative contract violation as specified in §355.8443 of this title.

(4) [~~(3)~~] For all other programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(i) Related party transactions.

(1) In determining whether a contracted provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. Related to a contracted provider means that the contracted provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, equipment, facilities, leases, or supplies. Common ownership exists if an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. Control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. If the elements of common ownership or control are not present in both organizations, then the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for cost-reporting purposes:

(A) husband and wife;

(B) natural parent, child, and sibling;

(C) adopted child and adoptive parent;

(D) stepparent, stepchild, stepsister, and stepbrother;

(E) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law;

(F) grandparent and grandchild;

(G) uncles and aunts by blood or marriage;

(H) nephews and nieces by blood or marriage; and

(I) first cousins.

(2) A determination as to whether an individual (or individuals) or organization possesses ownership or equity in the contracted provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the contracted provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be

determined by reference to the interest in the assets of the organization, e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation.

(3) The term control includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control exists. Since a determination made in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common.

(4) Costs applicable to services, equipment, facilities, leases, or supplies furnished to the contracted provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, the cost must not exceed the price of comparable services, equipment, facilities, leases, or supplies that could be purchased or leased elsewhere. The purpose of this principle is twofold: to avoid the payment of a profit factor to the contracted provider through the related organization (whether related by common ownership or control), and to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. The related organization's costs include all actual reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, leases, or supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the contracted provider itself. Therefore, if a cost would be unallowable if incurred by the contracted provider itself, it would be similarly unallowable to the related organization. The principles of reimbursement of contracted provider costs described throughout this title will generally be followed in determining the reasonableness and allowability of the related organization's costs, where application of a principle in a nonprovider entity would be clearly inappropriate.

(5) An exception is provided to the general rule applicable to related organizations. The exception applies if the contracted provider demonstrates by convincing evidence to the satisfaction of HHSC that certain criteria have been met. If all of the conditions of this exception are met, then the charges by the supplier to the contracted provider for such services, equipment, facilities, leases, or supplies are allowable costs. If Medicare has made a determination that a related party situation does not exist or that an exception to the related party definition was granted, HHSC will review the determination made by Medicare to determine if it is applicable to the current situation of the contracted provider and in compliance with this subsection (relating to related party transactions). In order to have the Medicare determination considered for approval by HHSC, a copy of the applicable Medicare determination must accompany each written exception request submitted to HHSC, along with evidence supporting the Medicare determination for the current cost-reporting period. If the exception granted by Medicare no longer is applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, HHSC may choose not to consider the Medicare determination. Written requests for an exception to the general rule applicable to related organizations must be submitted for approval to the HHSC Rate Analysis Department no later than 45 days prior to the due date of the cost report in order to be considered for that year's cost report. Each request must include documentation supporting that the contracted provider meets each of the four criteria listed in subparagraphs (A) - (D) of this paragraph. Requests that do not include the required documentation for each criteria will not be considered for that year's cost report.

(A) The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the contracted provider organization.

(B) A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the organization. In determining whether the activities are of similar type, it is important also to consider the scope of the activity. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arm's-length bargaining by well-informed buyers and sellers.

(C) The services, equipment, facilities, leases, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted client care ordinarily furnished directly to clients by such entities. This requirement means that entities such as the contracted provider typically obtain the services, equipment, facilities, leases, or supplies from outside sources, rather than producing them internally.

(D) The charge to the contracted provider is in line with the charge of such services, equipment, facilities, leases, or supplies in the open, competitive market and no more than the charge made under comparable circumstances to others by the organization for such services, equipment, facilities, leases, or supplies.

(6) Disclosure of all related-party information on the cost report is required for all costs reported by the contracted provider, including related-party transactions occurring at any level in the provider's organization, (e.g., the central office level, and the individual contracted provider level). The contracted provider must make available, upon request, adequate documentation to support the costs incurred by the related party. Such documentation must include an identification of the related person's or organization's total costs, the basis of allocation of direct and indirect costs to the contracted provider, and other business entities served. If a contracted provider fails to provide adequate documentation to substantiate the cost to the related person or organization, then the reported cost is unallowable. For further guidelines regarding adequate documentation, refer to §355.105(b)(2) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(7) When calculating the cost to the related organization, the cost-determination guidelines specified in this section and in §355.103 of this title apply.

(j) Cost allocation. Direct costing must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, (as defined in subsection (f)(3) - (4) of this section) incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. For example, the payroll costs of a direct care employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums,

life insurance premiums, and other employee benefits must be direct costed.

(1) If cost allocation is necessary for cost-reporting purposes, contracted providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities.

(A) The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. An indirect allocation method approved by some other department, program, or governmental entity is not automatically approved by HHSC for cost-reporting purposes.

(B) HHSC reviews each cost-reporting allocation method on a case-by-case basis in order to ensure that the reported costs fairly and reasonably represent the operations of the contracted provider. If in the course of an audit it is determined that an existing or approved allocation method does not fairly and reasonably represent the operations of the contracted provider, then an adjustment to the allocation method will be made consistent with subsection (f)(3) - (4) of this section. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title (relating to Informal Reviews and Formal Appeals).

(C) Any allocation method used for cost-reporting purposes must be consistently applied across all contracted programs and business entities in which the contracted provider has an interest.

(D) Providers must use an allocation method approved or required by HHSC. Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report and must be accompanied by a written explanation of the reasons and justification for such change. If the provider wishes to use an allocation method that is not in compliance with the cost-reporting allocation methods in paragraphs (3) - (4) of this subsection, the contracted provider must obtain written prior approval from HHSC's Rate Analysis Department.

(i) Requests for approval to use an allocation method other than those identified in paragraphs (3) - (4) of this subsection or for approval of a provider's change in cost-reporting allocation method other than those identified in paragraphs (3) - (4) of this subsection must be received by HHSC's Rate Analysis Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(ii) The HHSC Rate Analysis Department will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then HHSC may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title.

(iii) Failure to use an allocation method approved or required by HHSC or to disclose a change in an allocation to HHSC will result in the following.

(I) For nursing facilities, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC may result in vendor hold as specified in §355.403 of this title.

(II) For Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(III) For SHARS, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this title.

(IV) [~~(III)~~] For all other programs, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(2) Cost-reporting methods for allocating costs must be clearly and completely documented in the contracted provider's workpapers, with details as to how pooled costs are allocated to each segment of the business entity, for both contracted and noncontracted programs.

(A) If a contracted provider has questions regarding the reasonableness of an allocation method, that contracted provider should request written approval from the HHSC Rate Analysis Department prior to submitting a cost report utilizing the allocation method in question. Requests for approval must be received by the HHSC Rate Analysis Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(B) The HHSC Rate Analysis Department will forward its written decision to the contracted provider within 45 days of its receipt of the original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, HHSC may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title.

(3) When a building is shared and the building usage is separate and distinct for each entity using the building, the building costs, identified as building and facility cost categories on the cost report, should be allocated based upon square footage and may not be allocated with other indirect costs as a pool of costs. When the same building space is shared by various entities, the shared building costs, identified as building and facility cost categories on the cost report, should be allocated using a reasonable method which reflects the actual usage, such as an allocation based on time in shared activity areas or a functional study of shared dietary costs related to shared dining and kitchen areas.

(4) Where costs are shared, are not directly chargeable and are allocated as a pool of costs, the following allocation methods are acceptable for cost-reporting purposes.

(A) If all the business components of a contracted provider have equivalent units of equivalent service, indirect costs must be allocated based upon each business component's units of service. For example, if a provider had two nursing facilities, indirect costs requiring allocation as a pool of costs must be allocated based upon each nursing facility's units of service, since the units of service are equivalent units and the services are equivalent services. If a provider had a nursing facility and a residential care program, indirect costs requiring allocation as a pool of costs could not be allocated based upon units of service because even though the units of service for a nursing facility and a residential care facility are equivalent units, the services are not equivalent services. If a home health agency has indirect costs requiring allocation as a pool of costs across its Medicare home health services and its Medicaid primary home care services, it could not use units of service to allocate those costs, since neither the units of service nor the services are equivalent.

(B) If all of a contracted provider's business components are labor-intensive without programmatic residential facility or residential building costs, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based either on each business component's pro rata share of salaries or labor costs or on a cost-to-cost basis.

(i) For cost-reporting cost allocation purposes, the term "salaries" includes wages paid to employees directly charged to the specific business component. The term "salaries" also includes fees paid to contracted individuals, excluding consultants, who perform services routinely performed by employees, which are directly charged to the specific business component. The term "salaries" does not include payroll taxes and employee benefits associated with the wages of employees.

(ii) For cost-reporting cost-allocation purposes, the term "labor costs" includes salaries as defined in clause (i) of this subparagraph, plus the payroll taxes and employee benefits associated with the wages of the employees.

(iii) The cost-to-cost method allocates costs based upon the percentage of each business component's directly-charged costs to the total directly-charged costs of all business components.

(C) If a contracted provider's business components are mixed, with some being labor-intensive and others having a programmatic residential or institutional component, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs either:

(i) based upon the ratio of each business component's total costs less that business component's facility or building costs, as related to the contracted provider's total business component costs less facility or building costs for all the contracted provider's business components, with "facility or building costs" referring to those cost categories as identified on the cost report; or

(ii) based upon the labor costs method stated in subparagraph (B)(ii) of this paragraph.

(D) In order to achieve a more accurate and representative reporting of costs than results from allocating shared indirect costs as a pool of costs, a provider may choose to allocate its indirect shared expenses on an appropriate and reasonable functional basis. If allocating shared direct client care costs, a provider may use an appropriate and reasonable functional method. For example, costs of a central payroll operation could be allocated to all business components based on the number of checks issued; the costs of a central purchasing function could be allocated based on the number of purchases made or requisitions handled; payroll costs for an administrative employee working across business components could be directly charged based upon that employee's time sheets and/or allocated based upon a documented time study; food costs could be allocated based upon a functional study of shared dietary costs; transportation equipment costs could be allocated based upon mileage logs; and shared laundry costs could be allocated based upon a functional study of the number of pounds/loads of laundry processed. Providers choosing to allocate allowable employee-related self-insurance paid claims in accordance with §355.103(b)(10)(B)(ii) of this title should base the allocation on percentage of salaries of employees benefiting from the coverage for fully self-insured situations or on percentage of premiums of covered employees for partially self-insured situations since purchased premiums must be directly charged.

(E) Because the determination of reimbursement is based on cost data, allocation methods based upon revenue streams are inappropriate and unallowable.

(k) Net expenses. Net expenses are gross expenses less any purchase discounts or returns and allowances. Purchase discounts are cash discounts reducing the purchase price as a result of prompt payment, quantity purchases, or for other reasons. Purchase returns and allowances are reductions in expenses resulting from returned merchandise or merchandise which is damaged, lost, or incorrectly billed. Only net expenses may be reported on the cost report. Expenses reported on the cost report must be adjusted for all such purchase discounts or returns and allowances.

§355.103. Specifications for Allowable and Unallowable Costs.

(a) Introduction. The following list of allowable and unallowable costs is not comprehensive but serves as a guide and clarifies certain key expense areas. If a particular type of expense is classified as unallowable for purposes of reporting on a cost report, it does not mean that individual contracted providers may not make such expenditures. Except where specific exceptions are noted, the allowability of all costs is subject to the general principles specified in §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs). In addition, refer to program-specific allowable and unallowable costs, as applicable.

(1) Accounting and audit fees. See subsection (b)(2)(C)(i) of this section.

(2) Advertising and public relations. See subsection (b)(13) of this section.

(3) Amortization expense. See subsection (b)(7) of this section.

(4) Bad debt expense. See subsection (b)(17)(M) of this section.

(5) Boards of directors and trustees. See subsection (b)(2)(E) of this section.

(6) Bonuses. See subsection (b)(1)(A)(i) of this section.

(7) Central office costs. See subsection (b)(4) of this section.

(8) Charity allowance. See subsection (b)(17)(N) of this section.

(9) Compensation of employees. See subsection (b)(1) of this section.

(10) Compensation of owners and related parties. See subsection (b)(2) of this section.

(11) Compensation of outside consultants. See subsection (b)(2)(C) of this section.

(12) Courtesy allowance. See subsection (b)(17)(N) of this section.

(13) Depreciation expense. See subsection (b)(7) of this section.

(14) Donated revenues. See subsection (b)(15) of this section.

(15) Donated services, supplies, and assets. See subsection (b)(16) of this section.

(16) Dues or contributions to organizations. See subsection (b)(11) of this section.

(17) Employee relations expenses. See subsection (b)(17)(A) of this section.

(18) Employment-related taxes. See subsection (b)(9)(B) of this section.

(19) Endowment income. See subsection (b)(15) of this section.

(20) Expenses not related to contracted services. See subsection (b)(17)(H) of this section.

(21) Fines and penalties. See subsection (b)(17)(G) of this section.

(22) Franchise tax. See subsection (b)(9)(C) of this section.

(23) Finance charges. See subsection (b)(8)(E) of this section.

(24) Franchise fees. See subsection (b)(17)(C) of this section.

(25) Fringe benefits. See subsection (b)(1)(A)(iii) of this section.

(26) Fundraising activities. See subsection (b)(14) of this section.

(27) Gains on disposal of assets. See subsection (b)(7)(F) of this section.

(28) Gifts. See subsection (b)(15) of this section.

(29) Goodwill. See subsection (b)(7) and (17)(C)(ii) of this section.

(30) Grants, gifts and income from endowments. See subsection (b)(15) of this section.

(31) In-kind donations. See subsection (b)(16) of this section.

(32) Insurance expense. See subsection (b)(10) of this section.

(33) Interest expense. See subsection (b)(8) of this section.

(34) Legal fees. See subsection (b)(2)(C)(ii) of this section.

(35) Life insurance. See subsection (b)(10)(G) of this section.

(36) Litigation expenses and awards. See subsection (b)(17)(I) of this section.

(37) Lobbying costs. See subsection (b)(17)(J) of this section.

(38) Losses on disposal of assets. See subsection (b)(7)(F) of this section.

(39) Losses due to theft or embezzlement. See subsection (b)(17)(L) of this section.

(40) Management fees. See subsection (b)(3) of this section.

(41) Medicaid as payor of last resort. See subsection (b)(18) of this section.

(42) Medical supplies and medical costs. See subsection (b)(17)(F) of this section.

(43) Nonpaid workers. See subsection (b)(2)(D) of this section.

(44) Operating revenue. See subsection (b)(15)(D) of this section.

(45) Organization costs. See subsection (b)(17)(B) of this section.

(46) Payroll taxes and insurance. See subsection (b)(1)(A)(ii) of this section.

(47) Penalties. See subsection (b)(17)(G) of this section.

(48) Planning and evaluation expenses. See subsection (b)(7)(E) of this section.

(49) Promotional activities. See subsection (b)(14) of this section.

(50) Public relations. See subsection (b)(13) of this section.

(51) Repairs and maintenance. See subsection (b)(6) of this section.

(52) Research and development costs. See subsection (b)(17)(E) of this section.

(53) Salaries and wages. See subsection (b)(1) and (2) of this section.

(54) Self-insurance. See subsection (b)(10)(B) of this section.

(55) Staff training costs. See subsection (b)(12)(A) of this section.

(56) Startup costs. See subsection (b)(17)(D) of this section.

(57) Tax expense and credits. See subsection (b)(9) of this section.

(58) Travel costs. See subsection (b)(12)(B) of this section.

(59) Utilities. See subsection (b)(5) of this section.

(60) Volunteers. See subsection (b)(2)(D) of this section.

(61) Voucher-paid expenses. See subsection (b)(17)(K) of this section.

(62) Workers' compensation insurance. See subsection (b)(10) of this section.

(b) Allowable and unallowable costs.

(1) Compensation of employees. Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospi-

tal insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance.

(A) Allowable compensation of employees is compensation paid to employees in arm's-length transactions as nonowners and non-related parties and is subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client services. Guidelines for compensation of owners and related parties are specified in paragraph (2) of this subsection.

(i) A bonus is a type of compensation granted to employees as a wage enhancement. Bonuses paid to employees in arm's-length transactions are allowable costs, subject to the reasonable and necessary costs that must be incurred by providers in the provision of contracted client services. In determining the employee classification type, part-time employees may be considered a different classification type than full-time employees. To be allowable, bonuses to owners and/or related parties:

(I) must not represent any form of profit sharing and must not be determined on the level of profit earned by the contracted provider;

(II) effective with the 1997 cost report for Texas Department of Human Services (DHS) contracted providers and with the 2004 cost report for Texas Department of Mental Health and Mental Retardation (TDMHMR) contracted providers, must be clearly defined in a written agreement or employment policy;

(III) must not be made only to related parties, in which case the bonuses are unallowable costs;

(IV) must be based upon the same criteria for all members of the same employee classification type;

(V) must be made available to all employees of the same classification type, unless the employee classification type predominantly consists of related parties, in which case the bonuses are unallowable costs; and

(VI) must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(ii) Payroll taxes and insurance are described in paragraph (9) of this subsection, concerning tax expense and credits, and paragraph (10) of this subsection.

(iii) Benefits are amounts paid to or on behalf of an employee, in addition to direct salary or wages, and from which the employee, his dependent, or his beneficiary derives a personal benefit before or after the employee's retirement or death.

(I) Benefits paid to employees in arm's length transactions as nonowners and non-related parties are allowable costs, subject to the reasonable and necessary costs which must be incurred by providers in the provision of contracted client care. To be allowable, benefits paid to owners and/or related parties must not discriminate in favor of certain employees, such as employees who are officers, stockholders, or the highest paid individual(s) of the organization.

(II) Allowable benefits are reported on cost reports either as salaries and/or wages, as employee benefits, or as costs applicable to specific cost report line items, as specified in this subclause and in subclause (III) of this clause. Any benefit subject to payroll taxes is reported as salaries and wages. Allowable benefits that are routinely reported as salaries and wages include paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, as specified in subclause (III)(-c-) of this clause. Allowable benefits which are routinely reported as employee benefits include employer contributions to certain deferred compensation plans, as specified in subclause (III)(-a-) of this clause, employer contributions to an employee retirement fund or certain pension plans, as specified in subclause (III)(-b-) of this clause, and costs of certain employer-paid health, life, and disability insurance premiums, as specified in subclause (III)(-f-) of this clause. The contracted provider's unrecovered cost of meals and room and board furnished to direct care employees, uniforms, employee personal vehicle mileage reimbursement in accordance with paragraph (12) of this subsection, job-related training reimbursements in accordance with paragraph (12) of this subsection, and job certification renewal fees in accordance with paragraph (12) of this subsection are not to be reported as benefits but are to be reported as costs applicable to specific cost report line items, unless they are subject to payroll taxes, whereas they are reported as salaries and wages.

(III) Benefits include the following:

(-a-) Employer contributions to certain deferred compensation plans are reported as employee benefits. Deferred compensation is remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. For the cost to be allowable, the deferred compensation plan must be formal, established, and maintained by the contracted provider and communicated to all eligible employees. A formal plan is one that is provided for in a written agreement executed between the contracted provider and the participating employees. The plan must:

(-1-) prescribe the method for calculating all contributions to the fund;

(-2-) be funded with contributions made systematically to a funding agency outside the contracted provider's ownership or control, such as a trustee, an insurance company, or a custodial bank account;

(-3-) provide for the protection of the plan's assets;

(-4-) designate the requirements for vested benefits;

(-5-) provide the basis for the computation of the amounts of benefits to be paid;

(-6-) be expected to continue despite normal fluctuations in the contracted provider's economic experience; and

(-7-) use all fund contributions and earnings for the sole benefit of the participating employees. Contributions made during the cost-reporting period to a deferred compensation plan meeting the requirements specified in subitems (-1-) - (-7-) of this item which represent legal obligations of the contracted provider and which are clearly enumerated as to dollar amount are allowable costs and should be reported on cost reports as employee benefits. Reasonable trustee or custodial fees paid by the contracted provider will be allowed as an administrative cost. However, such fees will not be allowable where the deferred compensation plan provides that they will be paid out of the corpus or earnings of the fund. To be allowable, contributions representing the employee's share cannot revert to the contracted provider. However employer-paid contributions can revert back to the contracted provider in the event an employee does not vest if designated in the requirements for vested benefits.

(-b-) Employer contributions to an employee retirement fund or certain pension plans are reported as employee benefits. A pension plan is a type of deferred compensation plan which is established and maintained by the employer to provide systematic payment of definitely determinable benefits to its employees over a period

of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. A pension plan must meet all the requirements of a deferred compensation plan. All employees' pension fund rights must be nonforfeitable after such time as they vest under the plan. Pension fund rights cannot be contingent on continuance of employment or other factors. Only the amount the contracted provider or employer contributed to the pension fund during the reporting period is allowable and should be reported as an employee benefit. To be allowable, contributions representing the employee's share cannot revert to the contracted provider. However employer-paid contributions can revert to the contracted provider in the event an employee does not vest.

(-c-) Paid leave is reported as salaries or wages. Paid vacations, paid holidays, sick leave, voting leave, court or jury duty leave, and/or all-inclusive paid days, all are reported as employee salaries and/or wages rather than as employee benefits, as follows:

(-1-) A vacation benefit is a right granted by an employer to an employee to be absent from his job for a stipulated period of time without loss of pay or to be paid an additional salary in lieu of taking a vacation. The contracted provider's vacation policy must be consistent among all employees of a specific category. Vacation expense subject to payroll taxes must be reported as salaries and wages. Accrued vacation expense not yet subject to payroll taxes must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages.

(-2-) The cost of sick leave taken, or payment in lieu of sick leave taken, is not to exceed the salary or wage the employee would have earned had they reported for work. Sick leave costs subject to payroll taxes must be reported as salaries and wages. Accrued sick leave costs not yet subject to payroll taxes must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages.

(-3-) A formal plan for all-inclusive paid days off (PDO) is one under which all employees earn accrued vested leave, or payment in lieu of leave taken, for an unallocated combination of occasions such as illness, medical appointments, holidays, vacations, family leave, and care of a sick child, based on actual hours worked. The cost of PDO subject to payroll taxes must be reported as salaries and wages. Accrued costs of PDO not yet subject to payroll taxes must be reported as employee benefits. Providers must maintain adequate documentation to substantiate that costs reported one year as accrued benefits are not also reported, either the same or another year, as salaries and wages.

(-d-) Provider-paid instructional courses benefiting the employer's interest are not to be reported as employee benefits, but are to be reported as costs related to specific cost report line items. Costs related to provider-paid instructional courses for the benefit of the employee only are unallowable costs. Refer to paragraph (12)(A) of this subsection, concerning staff training costs.

(-e-) Contracted provider's unrecovered cost of meals and room and board furnished on-site to direct care employees are not to be reported as employee benefits, but are to be reported as costs related to specific cost report line items. Any reasonable unrecovered cost of meals and/or room and board furnished on-site by a contracted provider to its direct care employees, which are equivalent to the meals and/or room and board provided to clients, are allowable costs since they are related to client care in that such reasonable costs are appropriate and helpful in developing and maintaining the contracted provider's operations to deliver contracted services. Such allowable costs should be reported in the cost area where the costs were incurred, such as meal costs being reported in the cost area associated with food and meal preparation and room and/or board costs being reported in the cost area associated with building costs.

(-f-) Costs of health, disability and life insurance premiums paid or incurred by the contracted provider if the benefits of the policy are payable to the employee or his beneficiary are reported as employee benefits. Report allowable health, disability, and life insurance premium costs as employee benefits. Refer to paragraph (10) of this subsection, concerning insurance expense.

(B) Compensation of employees that is not clearly enumerated as to dollar amount or which represent profit or surplus revenue distributions are unallowable costs. Accrued expenses that are not legal obligations of the contracted provider are unallowable costs, including any form of profit sharing and the accrued liabilities of unfunded deferred compensation plans.

(2) Compensation of owners and related parties. Compensation includes both cash and non-cash forms of compensation subject to federal payroll tax regulations. Compensation includes withdrawals from an owner's capital account; wages and salaries (including bonuses); payroll taxes and insurance; and benefits. Payroll taxes and insurance include Federal Insurance Contributions Act (old age, survivors, and disability insurance (OASDI) and Medicare hospital insurance); Unemployment Compensation Insurance; and Workers' Compensation Insurance. Allowable compensation must be reported as salaries and not as management fees. This paragraph applies to the compensation of owners and related parties unless limits or caps on the compensation of owners and related parties are stated in the program specific rules, then those limits or caps take precedence.

(A) Allowable compensation of owners and related parties.

(i) A person who is a sole proprietor, partner, or corporate stockholder-employee owning any of the outstanding stock of the contracted provider is considered an owner for the purposes of this subparagraph. Allowable compensation for a related party, as defined in §355.102(i) of this title, a sole proprietor-employee, a partner-employee, or a corporate stockholder-employee is governed by the principles that the services rendered are necessary functions and that the remuneration is the reasonable value of the services rendered.

(I) A function is deemed necessary when, if the owner or related party had not performed said function, the contracted provider would have had to employ another person to perform that function. To be necessary, a function must pertain to direct or indirect activities in the provision or supervision of contracted client services. The fact that an owner may have potential supervisory and managerial authority and responsibility is not as important as the manner in which this authority and responsibility is actually exercised. As an example, the right of the owner-administrator to overrule decisions does not solely constitute a basis for recognition of compensation comparable to nonowner-administrators.

(II) The test of reasonableness requires that the compensation of owners or related parties be such an amount as would ordinarily be paid for comparable services performed by nonowners or unrelated parties. Reasonable compensation is limited to the fair market value of services rendered by the owner or related party in connection with contracted client care. Education and experience of the owner are pertinent only as they relate to the job being performed and the services being rendered. For example, where an owner-administrator is also a physician or a nurse or a lawyer, but the services evaluated

are administrative in nature rather than the actual practice of medicine or nursing or law, the allowable compensation is based on the compensation nonphysician or nonnurse or nonlawyer administrators receive rather than on the rate physicians or nurses or lawyers receive for their professional services.

(ii) The compensation must be for services performed by the related party, owner, partner, or stockholder that do not duplicate services performed by another employee of the contracted provider.

(iii) Compensation for "full-time" service requires that at least 40 hours per week be devoted to the duties of the position for which compensation is requested. For owners devoting less than 40 hours per week to the position, allowable compensation is limited to the proportion of 40 hours actually devoted to the contract services. Documentation regarding owners and related parties must be kept in accordance with §355.105(b)(2)(B)(xi) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(iv) Compensation must be in accordance with paragraph (1)(A) of this subsection concerning compensation of employees, must be made in regular periodic payments, must be subject to payroll or self-employment taxes, and must be verifiable by adequate documentation maintained by the contracted provider.

(B) Unallowable compensation of owners and related parties.

(i) Forms of compensation that are not clearly enumerated as to dollar amount or that represent profit or surplus revenue distributions are unallowable costs.

(ii) Compensation in the form of salaries, benefits, or any form of perquisite provided to owners, partners, officers, directors, stockholders, employees, or others who do not provide services directly to clients or who do not provide services required in the normal conduct of operations to provide contracted client services, is an unallowable cost. Services which would be required in the normal conduct of operations to provide contracted client services would include expenses such as administration of the program or supervision of direct care staff.

(C) Compensation for outside consultants and fees for services provided by outside vendors. Allowable compensation for outside consultants and contracted services must meet the criteria in §355.102 of this title. Specific criteria for certain types of compensation of outside consultants and contracted services are as follows:

(i) Accounting and audit fees.

(I) Allowable accounting and audit fees. Fees for preparation of business tax reports and returns, financial statements, and cost reports are allowable costs. Audit fees associated with the performance of a financial audit are allowable costs.

(II) Unallowable accounting and audit fees. Expenses related to the preparation of personal tax returns are unallowable costs as are certain taxes. Refer to paragraph (9) of this subsection, concerning tax expense and credits. Audit fees associated with the performance of a single audit are unallowable costs. The cost attributable to a financial audit that was conducted along with a single audit is allowable if the cost of the financial audit can be identified separately from the cost attributable to the single audit. Accounting fees and related costs associated with litigation between a provider and a governmental entity are unallowable. Accounting costs associated with any other unallowable costs are also unallowable. Fees related to the preparation of annual reports, reports to stockholders or other interested parties, or for investment management are unallowable costs.

(ii) Legal fees. Legal retainers are not allowable in and of themselves, but rather must be documented as specified in §355.105(b)(2)(B)(viii) of this title. Legal costs associated with litigation between a provider and a governmental entity are unallowable. Legal costs associated with any other unallowable costs are also unallowable.

(D) Value of services of nonpaid workers. Since the contracted provider incurs no actual costs for nonpaid and/or volunteer workers, the value of the nonpaid work is not an element of cost; and the value of such nonpaid work is an unallowable cost.

(E) Boards of directors and trustees. Fees and expenses related to boards of directors and trustees are unallowable costs except for:

(i) Travel costs incurred by the contracted provider's board members or trustees to attend meetings of the contracted provider's board of directors or trustees are allowable costs in accordance with the travel guidelines as stated in paragraph (12)(B) of this subsection; and

(ii) Errors and omissions (liability) insurance for boards of directors or trustees are allowable costs.

(3) Management fees.

(A) Allowable management fees. Reasonable management fees paid to unrelated parties are allowable costs. Allowable management fees paid to related parties are the actual costs to the related party for the materials, supplies, and services provided directly to the individual contracted provider. Any related party compensation or owner compensation included in allowable management fees paid to related parties must follow the guidelines specified in §355.102(i) of this title and in paragraph (2) of this subsection, concerning compensation of owners and related parties. Expenses for management provided by the contracted provider's central office must be reported as central office costs on the cost report. Cash management fees related to minimizing interest costs and banking expenses in the management of operating revenue necessary for contracted services are allowable costs.

(B) Unallowable management fees. Fees for management of personal investments or investments not necessary for the provision of contracted services are unallowable costs.

(4) Central office costs. A chain organization consists of a group of two or more contracted entities which are owned, leased or controlled through any other arrangement by one organization. A chain may also include business organizations which are engaged in other activities and which are not contracted program entities. Central offices of a chain organization vary in the services furnished to the components in the chain. The relationship of the central office to an entity providing contracted services is that of a related party organization to a contracted provider. Central offices usually furnish central management and administrative services such as central accounting, purchasing, personnel services, management direction and control, and other necessary services. To the extent the central office furnishes services related directly or indirectly to contracted client care, the reasonable costs of such services are allowable. Allowable central office costs include costs directly related to those services necessary for the provision of client care for contracted services in Texas and an appropriate share of allowable indirect costs. Where functions of the central office have no direct or indirect bearing on delivering contracted client care, the cost for those functions are not allowable costs. Costs which are unallowable to the contracted provider are also unallowable as central office costs. Where a contracted provider is furnished services, facilities,

leases, or supplies from its central office, the costs allowed are subject to the guidelines of related party transactions in §355.102(i) of this title. Owner-employees and related parties receiving compensation for services provided through the central office are allowable to the extent provided in paragraph (2)(A) and (B) of this subsection, concerning compensation of owners and related parties.

(5) Utilities. To be allowable, the utilities must be used directly or indirectly in the provision of contracted services.

(6) Repairs and maintenance. For cost-reporting purposes, repairs and maintenance are categorized as ordinary or extraordinary (major) repairs and should be handled as follows.

(A) Ordinary repairs and maintenance are defined as outlays for parts, labor, and related supplies that are necessary to keep the asset in operating condition, but neither add materially to the use value of the asset nor prolong its life appreciably. Ordinary repairs are recurring and usually involve relatively small expenditures. Ordinary repairs include, but are not limited to, painting, wall papering, copy machine repair, repairing an electrical circuit, or replacing spark plugs. Because maintenance costs and ordinary repairs are similar, they are usually combined for accounting purposes. Ordinary repairs may be expensed.

(B) Extraordinary repairs (major repairs) involve relatively large expenditures, are not normally recurring in nature, and usually increase the use value (efficiency and use utility) or the service life of the asset beyond what it was before the repair. Extraordinary repairs costing $2,500 [~~$1,000~~] or more, with a useful life in excess of one year, should be capitalized and depreciated. The cost of the extraordinary repair should be added to the cost of the asset and depreciated over the remaining useful life of the original asset. If the life of the asset has been extended due to the repair, the useful life should be adjusted accordingly. Extraordinary repairs include, but are not limited to, major vehicle overhauls, major improvements in a building's electrical system, carpeting an entire building, replacement of a roof, or strengthening the foundation of a building.

(7) Depreciation and amortization expense. For DHS contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 1997, an asset valued at $1,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than $1,000 or having a useful life of one year or less. For purchases made after the beginning of the contracted provider's fiscal year 2004, an asset valued at $2,500 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than $2,500 or having a useful life of one year or less. For TDMHMR contracted providers: for purchases made after the beginning of the contracted provider's fiscal year 1997, an asset valued at $2,500 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method. In determining whether to expense or depreciate a purchased item, a contracted provider may expense any single item costing less than $2,500 or having a useful life of one year or less. Depreciation and amortization expenses for unallowable assets and costs are also unallowable, including amounts in excess of those resulting from the straight line method, capitalized lease expenses in excess of actual lease payments, and goodwill or any excess above the actual value of physical assets at the time of purchase. The minimum useful lives to be assigned to common classes of depreciable property are as follows:

(A) Buildings. A building's life must be reported as a minimum of 30 years, with a minimum salvage value of 10%. All buildings, excluding the value of the land, are uniformly depreciated on a 30-year life basis, regardless of the actual date of construction or original purchase. Exceptions to this policy are permissible when contracted providers choose a useful-life basis in excess of 30 years. An example of depreciation on a 30-year life basis is:
Figure: 1 TAC §355.103(b)(7)(A) (No change.)

(B) Building equipment; buildings and grounds improvements and repairs; durable medical equipment, furniture, and appliances; and power equipment and tools used for buildings and grounds maintenance. Use minimum schedules consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association. Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., 737 North Michigan Ave., Chicago, IL 60611 or at www.aha.org. Leasehold improvements whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the term of the lease must be depreciated and/or amortized over the life of the leasehold improvement. Building improvements which are not structural in nature and do not extend the depreciable life of the building, but whose estimated useful lives according to the guidelines for depreciable hospital assets are longer than the remaining depreciable life of the building, must be depreciated over the normal useful life of the building improvements. Once the estimated useful life of the leasehold improvement has been established using the guidelines above, subsequent extensions of the lease period do not change the useful life of the leasehold improvement. Any exceptions to this policy shall be stated in each program-specific reimbursement methodology rules.

(C) Transportation equipment used for the transport of clients, staff, or materials and supplies utilized by the contracted provider. Cost reporting must reflect a minimum of three years for automobiles (including minivans); five years for light trucks and vans (up to and including 15-passenger vans); and seven years for buses and airplanes. Depreciation expenses for transportation equipment not generally suited or not commonly used to transport clients, staff, or provider supplies are unallowable costs. This includes motor homes and recreational vehicles; sports automobiles; motorcycles; heavy trucks, tractors and equipment used in farming, ranching, and construction; and transportation equipment used for other activities unrelated to the provision of contracted client care, unless program-specific reimbursement methodology rules provide otherwise. Refer to §355.105(b)(2)(B)(iii) of this title for requirements for the maintenance of mileage logs and other documentation required to substantiate transportation equipment costs.

(i) Luxury automobiles are defined for cost-reporting purposes as passenger vehicles, including automobiles, light trucks, and vans (up to and including 15-passenger vans) and excluding buses, with an historical cost at time of purchase or a market value at execution of the lease exceeding $30,000 when purchased or leased before January 1, 1997. For vehicles leased or purchased on or after January 1, 1997, luxury vehicles are defined as a base value of $30,000 with 2.0% being added (using the compound method) to the base value each January 1 beginning on January 1, 1998. Any amount above the definition of a luxury vehicle stated above is an unallowable cost. When a passenger vehicle's cost exceeds the amount determined by the definition of a luxury vehicle stated above, the historical cost is reduced to the amount determined by the definition of a luxury vehicle. When a passenger vehicle's market value at the execution of the lease exceeds the amount determined by the definition of a luxury vehicle stated above, the allowable lease payment is limited to the lease amount for a vehicle with the base value as determined above, with substantiating documen-

tation as specified in §355.105(b)(2)(B)(iv) of this title. Luxury vehicles must be depreciated according to depreciation guidelines in this paragraph. Expenses for passenger luxury vehicles will be allowable if the contracted provider maintains adequate mileage logs substantiating the use of the luxury vehicles to transport clients, contracted provider staff or provider supplies. Refer to §355.105(b)(2)(B)(iii) of this title for requirements for the maintenance of mileage logs. The base value does not include specialized equipment, such as wheelchair lifts, added to assist clients.

(ii) The estimated life of a previously owned (used) vehicle is the longer of the number of years remaining in the vehicle's depreciable life or three years. For example, if a 1994 van were purchased in 1995, it would have four years remaining in its five-year depreciable life and that would become the depreciable life for the used vehicle. If a 1994 minivan were purchased in 1995, it would have two years remaining in its three-year depreciable life and the depreciable life for the used vehicle would then be three years.

(iii) Specialized equipment added to a vehicle to assist a client should be depreciated separately from the vehicle. Wheelchair lifts have an estimated useful life of four years.

(D) Depreciation for the first reporting period. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting period. Depreciation on disposal is based on the length of time from the beginning of the reporting period in which the asset was disposed to the date of disposal.

(E) Planning and evaluation expenses. Planning and evaluation expenses for the purchase of depreciable assets are allowable costs only where purchases are actually made and the assets are put into service in the provision of care by the provider for contracted services.

(F) Gains and losses. Gains and losses realized from the trade-in or exchange of depreciable assets are included in the determination of allowable cost. When an asset is acquired by trading-in an asset that was being depreciated, the historical cost of the new asset is the sum of the undepreciated cost of the asset traded-in plus any cash or other assets transferred or to be transferred to acquire the new asset. Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are includable as allowable costs in the year of involuntary conversion, provided the total aggregate allowable losses incurred in any cost-reporting period do not exceed $5,000 and provided the assets are replaced. If the total aggregate allowable losses in any cost-reporting period exceed $5,000, the total amount of the losses over $5,000 is recognized as a deferred charge and treated as follows:

(i) If a depreciable asset is destroyed by an involuntary conversion beyond repair, then the amount of the loss over $5,000 must be capitalized as a deferred charge over the estimated useful life of the asset which replaces it. The allowable loss for a total casualty is the undepreciated cost of the asset, less insurance proceeds, gifts, and grants from any source as a result of the involuntary conversion. If the unrepairable asset is disposed of by scrapping, income received from salvage is treated as a reduction in the amount of the allowable loss. Conversely, where additional expense is incurred in the scrapping operation, such cost would be added to the allowable loss of the destroyed asset.

(ii) If a depreciable asset is partially destroyed or damaged as a result of an involuntary conversion, a reduction in its cost basis is assumed to have taken place. Therefore, the cost basis of the asset must be reduced to reflect the amount of the casualty loss, regardless of whether the loss is covered by insurance.

(I) The amount of the casualty loss is the difference between the fair market value immediately before the casualty and the fair market value immediately after the casualty; however, for cost-reporting purposes, the allowable loss is limited to the percent of loss in fair market value applied to the net book value of the asset at the time the casualty occurred. This method of calculating the allowable loss recognizes the actual reduction in the cost value of the asset rather than the reduction in replacement value.

(II) Any loss over $5,000 must be capitalized as a deferred charge and amortized over the useful life of the restored asset.

(III) The fair market value generally can be ascertained by competent appraisal. If no appraisal is made, the cost of repairs to the damaged property is acceptable as evidence of the loss of value if the repairs restore the property to its condition immediately before the casualty and, as a result of the repairs, the value of the property has not been increased. The amount of the allowable loss is then deducted from the cost basis of the asset before the casualty, to arrive at the adjusted cost basis of the asset. Any insurance proceeds received or recoverable must be deducted from the amount of the casualty loss to determine the gain or the loss.

(IV) Actual costs incurred in the restoration of an asset are added to the adjusted cost basis of the asset to arrive at the revised cost of the restored asset and capitalized over the remaining useful life of the restored asset.

(V) When the repairs materially improve or add to the value or utility of the property or appreciably prolong its useful life, the repairs must be depreciated over the estimated life of the repairs.

(VI) When the contracted provider maintains a self-insurance reserve fund, the amount of the casualty loss recognized as an allowable cost is limited to the lesser of the decrease in fair market value, as adjusted, of the damaged or destroyed asset or the amount of cash, and/or investments, comprising the accumulated balance of the self-insurance reserve account.

(VII) When an asset is sold before the end of its useful life and a gain is realized (the sales price is greater than the remaining allowable depreciation), no additional depreciation or expense is allowed.

(8) Interest expense. Reasonable and necessary interest on current and capital indebtedness is an allowable cost. In the case of allowable interest incurred on a loan, in order to be determined necessary, the loan must have been made to satisfy a financial need for a purpose reasonably related to contracted client care.

(A) For cost-reporting purposes, allowable interest expenses are limited to that net portion of interest accrued which has not been reduced or offset by interest income. Refer to §355.104(5) of this title (relating to Revenues). To be allowable, the following requirements must be met:

(i) the loan must be supported by evidence in writing of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required and systematically made. Refer to §355.105(b)(2)(B)(ii) of this title;

(ii) the loan must be made in the name of the contracted provider entity as maker or comaker of the note; and

(iii) the proceeds of the note or loan must be used for allowable costs.

(B) Interest expense on a demand note is allowable if the loan is the result of an arm's-length transaction.

(C) Where the lender is a related party, allowable interest is limited to the prevailing national average prime interest rate in effect at the time at which the loan contract was finalized, as reported by the United States Department of Commerce, Bureau of Economic Analysis, in the Survey of Current Business.

(D) Interest costs incurred during the period of construction or enlarging of a building must be capitalized as part of the cost of the building.

(E) Reasonable finance charges and service charges, together with interest on indebtedness, are allowable costs.

(F) Other fees associated with obtaining an allowable loan, such as broker's fees to solicit financing, lender's fees, attorney's fees, and due diligence fees, are allowable costs.

(G) Interest expenses on funds borrowed for purposes of investing in operations other than contracted services, on loans pertaining to unallowable items, and on borrowed funds creating excess working capital are unallowable costs.

(9) Tax expense and credits.

(A) Generally, taxes assessed against the contracted provider, in accordance with the levying enactments of Texas and lower levels of government and for which the contracted provider is liable for payment, are allowable costs. Tax expense based on fines and penalties are unallowable costs.

(B) Employment-related taxes such as Federal Insurance Contribution Act (FICA), Workers' Compensation and Unemployment Compensation, are allowable costs. Refer to paragraph (1) and (1)(A) of this subsection.

(C) Franchise taxes are allowable costs. A franchise tax is a periodic assessment, as defined by the Texas Comptroller of Public Accounts and paid to the Texas State Treasurer, levied on the operation of a business in the State of Texas. Franchise taxes do not refer to franchise fees, which are the costs associated with a company's granting the right to sell its products or services in a specified territory.

(D) Unallowable taxes include:

(i) federal income taxes and excess profit or surplus revenue based taxes, including any interest or penalties paid thereon. However, fees for preparation of business tax reports and business returns required by law are allowable;

(ii) state or local income and excess profit or surplus revenue based taxes. However, fees for preparation of business tax reports and/or business returns are allowable;

(iii) taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are, however, unallowable as tax expense;

(iv) taxes from which exemptions are available to the contracted provider;

(v) special assessments on land which represent capital improvements should be capitalized and depreciated over their estimated useful lives and are not allowable as tax expenses;

(vi) taxes, such as sales taxes, levied against the client and collected and remitted by the contracted provider; and

(vii) self-employment taxes.

(10) Insurance expense. This section covers the following types of insurance: property damage and destruction; fire and casualty; malpractice and comprehensive general liability; errors and omissions insurance covering boards of directors; theft insurance (fidelity bonds and burglary insurance); workers' compensation; transportation equipment insurance; life insurance for owners, officers, and key employees; health; disability; and unemployment compensation.

(A) Purchased and commercial insurance. The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation are allowable if resulting from an arm's-length transaction. The commercial carrier or nonprofit service corporation must meet the standards as set by the Texas Department of Insurance. Costs of insurance purchased from a limited purpose insurer are allowable if they are not in excess of the cost of available comparable commercial insurance premiums and meet the reasonable cost provisions. If comparable insurance premiums are not available, the limited purpose insurer or captive insurance company must obtain an evaluation of the adequacy and reasonableness of its insurance premium by an independent actuary, commercial insurance company, or broker.

(B) Self-insurance. Self-insurance is a means whereby a contracted provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. To qualify as an allowable self-insurance plan, a contracted provider must enter into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party designed to provide only administrative services to liquidate those liabilities and manage risks. Self-insurance costs for contracted providers who have received certificates of authority to self-insure from the Texas Workers' Compensation Commission are allowable costs. Self-insurance costs in excess of costs for similar, comparable coverage by purchased and/or commercial insurance premiums are subject to a cost ceiling in accordance with subparagraph (E)(i) - (iv) of this paragraph. Documentation substantiating the cost of comparable coverage by purchased and/or commercial insurance premiums must be obtained and maintained as specified in §355.105(b)(2)(B)(ix) of this title.

(i) Costs related to self-insurance are allowable on a claims-paid basis. Contributions to the self-insurance fund or reserve which do not represent payments based on current liabilities are not considered actual incurred expenses and are not allowable costs. For cost-reporting purposes, self-insurance costs are reported on a cash basis. For cost-reporting purposes, compensation paid to employees who have been injured on the job is allowable and should be reported as compensation according to the type of compensation expense incurred in accordance with paragraphs (1) and (2) of this subsection.

(ii) For cost-reporting purposes, allowable employee-related paid claims, such as health insurance and workers' compensation costs, may either be directly charged to the business component in which the employee worked or may be allocated across all business components as an administrative expense. The method chosen to report these costs must remain consistent each year. Changes in the method for reporting those costs must be approved in accordance with §355.102(j) of this title.

(C) Determining self-insurance or purchased commercial insurance. There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance. Contributions to a special risk management fund or pool that is operated by a third party that assumes some of the risk and that has an annual actuarial review are allowable costs. Examples of such special risk management funds

and pools include the Texas Council Risk Management Fund and the Texas Municipal League Intergovernmental Risk Pool.

(D) Reporting of insurance costs. All allowable insurance premium costs should be reported on cost reports, with amounts accrued for premiums, modifiers, and surcharges during the cost-reporting period being adjusted by any refunds and discounts actually received or settlements paid during the same cost-reporting period.

(E) Losses in excess of coverage. When a contracted provider is not fully insured by a purchased commercial insurance policy, i.e., the provider's coverage includes coinsurance provisions and/or deductibles, the amount of allowable insurance costs reported for each cost-reporting period is subject to a cost ceiling.

(i) The cost ceiling for employee-related insurance, such as health insurance, or workers' compensation coverage, is either the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy or an amount equal to 10% of the payroll for employees eligible for such coverage. This cost ceiling is applied separately to employee-related insurance and to workers' compensation coverage.

(ii) The cost ceiling for non-employee-related insurance, such as malpractice insurance, comprehensive general liability insurance, or property insurance, is the amount that would have been incurred had the provider purchased full coverage for its entire business entity through a commercial insurance policy.

(iii) If, during a cost-reporting period, a provider incurs allowable paid claims in excess of the applicable cost ceiling, the provider reports on its current cost report allowable insurance costs up to the amount of the applicable cost ceiling, with the allowable costs in excess of the applicable cost ceiling being carried forward to future cost-reporting periods. When, during a future cost-reporting period, a provider incurs allowable insurance costs in an amount less than the applicable cost ceiling, the provider reports on its cost report the allowable insurance costs (paid claims) incurred during that cost-reporting period plus any allowable carry forward amount up to the amount of the applicable cost ceiling, with any excess carry forward being carried forward to future cost reporting periods.

(iv) Documentation requirements are stated in §355.105(b)(2)(B)(ix) of this title.

(F) Absence of coverage. Where a contracted provider, other than a governmental provider, has no insurance protection, the reporting of the provider's paid claims must follow the guidelines stated in subparagraph [~~paragraph (10)~~](E) of this paragraph [~~subsection~~]. For governmental providers, allowable paid claims for cost-reporting purposes include all claims paid during the cost-reporting period only if the provider demonstrates that it has a claims management and risk management program.

(G) Life insurance costs.

(i) In general, premiums related to insurance on the lives of owners, officers, and key employees where the contracted provider is a direct or indirect beneficiary are unallowable costs.

(ii) Life insurance costs are allowable if:

(I) a contracted provider is required by a lending institution or other lender to purchase such insurance to guarantee the outstanding loan balance;

(II) the lending institution or other lender must be designated as the beneficiary of the insurance policy; and

(III) upon the death of the insured, the proceeds are restricted to paying off the balance of the loan.

(iii) Allowable insurance premiums are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance or that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy. In addition, the loan must be reasonable and necessary and must meet the criteria for allowable loans and interest expense as stated in subsection (b)(8) of this section.

(iv) Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where the individual's relatives or his estate are the beneficiary are considered to be employee benefits to the individual and are allowable costs to the extent such employee benefits are allowable. Provider-paid premiums related to insurance on the lives of owners-employees, officers, and key employees where required by a financial institution and the financial institution is the beneficiary is allowable.

(H) Insurance costs pertaining to unallowable costs. Insurance costs pertaining to items of unallowable costs are themselves unallowable costs.

(I) Board of directors' or trustees insurance. Errors and omissions insurance (liability) on members of boards of directors or trustees is an allowable cost.

(11) Dues or contributions to organizations.

(A) Allowable dues and contributions to organizations. Costs are allowable for membership in professional associations directly and primarily concerned with the provision of services for which the provider is contracted. Allowable costs of memberships in such organizations include initiation fees, dues, and subscriptions to related professional periodicals. Allowable costs related to meetings and conferences whose primary purpose is to disseminate information for the advancement of contracted client care or the efficient operation of the contracted program include reasonable travel costs in accordance with paragraph (12)(B) of this subsection and reasonable registration fees and other costs incidental to those functions. Travel costs incurred by members of the board of directors of professional associations that are directly and primarily concerned with the provision of services for which the provider has contracted are allowable in accordance with paragraph (12)(B) of this subsection. Dues or licensing fees related to maintaining the professional accreditation or license of an employee are allowable to the extent that the professional accreditation or license is directly related to and necessary for the performance of that employee's functions.

(B) Unallowable dues and contributions to organizations. Dues to nonprofessional organizations are unallowable. Assessments whose purpose is to fund lawsuits or any legal action against the state or federal government are unallowable. Portions of dues based on revenue or for the purposes of lobbying, or campaign contributions are unallowable costs. Costs of membership in civic organizations whose primary purpose is the promotion and implementation of civic objectives are unallowable. Dues or contributions made to any type of political, social, fraternal, or charitable organization are unallowable. Chamber of Commerce dues are unallowable. Franchise fees are not considered dues or contributions to organizations.

(C) Dues to purchasing organizations or buying clubs. Allowable dues to purchasing organizations or buying clubs are limited to the pro-rata amount representing purchases made for use in providing contracted services.

(12) Training and travel costs.

(A) Staff training costs.

(i) Staff training costs refer to costs associated with educational activities for provider staff. To qualify as an allowable staff training cost, the training must:

(I) have a direct relationship with the employee's job responsibilities, thereby increasing the quality of contracted client care or the efficient operation of the contracted provider. Management training, if it is designed to enhance quality or improve administration and is relevant to the contracted service, is an allowable cost. The following apply to staff training costs.

(-a-) Non-related party staff. Costs of tuition, books, and related fees for courses required to complete the designated degree or certification are allowable. The degree or certification must be necessary to the provision of contracted client services of the contracted provider. An example would be any course required to be taken by a licensed vocational nurse (LVN) working toward a degree as a registered nurse (RN) where RN services are necessary to deliver services as required under the contract.

(-b-) Related party staff. Allowable costs are restricted to specific courses which have a direct relationship with the employee's job responsibilities. Examples of allowable staff training costs include tuition, books, and related fees for an accounting course for a bookkeeper and a management course for a supervisor. However, a history course for a bookkeeper, even though it may be a requirement for a college degree in accounting or business, is unallowable.

(II) be located within the state of Texas unless the purpose of the training is for staff training in contracted client care-related services or quality assurance which is not available in the state of Texas. All costs for training outside the continental United States are unallowable costs. For further guidelines regarding adequate documentation, refer to §355.105(b)(2)(B)(vi) of this title.

(ii) Staff training may be conducted within the provider setting or off-site. It may be operated by the contracted provider, provided by an accredited academic or technical institution, or conducted by a recognized professional organization for the particular training activity. Workshops on particular contracted client services, health applications, on-the-job safety, data processing, accounting, the Texas Health and Human Services Commission (HHSC) programmatic or cost related training, supervisory techniques, and other administrative activities are examples of allowable types of training. Costs of orientation, on-the-job training, and in-service training are recognized as normal operating costs and are allowable training costs.

(iii) For staff training conducted within the provider setting, allowable training costs include, but are not limited to, instructor and consultant fees, training supplies, and visual aids. For off-site training, allowable costs include costs such as allowable travel costs, registration fees, seminar supplies, and classroom costs. For additional guidelines regarding allowable travel costs, please refer to subparagraph [~~paragraph (12)~~](B) of this paragraph [~~subsection~~].

(iv) Staff training costs must be reported as net costs, having been offset by any reimbursement from grants, tuitions, or donations received for staff educational purposes.

(v) For information regarding nursing facility nurse aide training, refer to paragraph (17)(K) of this subsection and program-specific reimbursement methodology rules.

(vi) For guidelines on allowability for client prevocational, vocational, and educational costs, refer to program-specific reimbursement methodology rules for guidelines on allowability.

(B) Travel costs.

(i) Maximum allowable travel costs for allowable activities are as follows:

(I) 150% of the limits established by the Texas Legislature for non-exempt state employees, with respect to hotel costs and per diem rates; and

(II) the maximum allowable mileage reimbursement amount set by the Texas Legislature for non-exempt state employees.

(ii) Out-of-state travel costs are unallowable, unless the purpose of the travel is for staff training in contracted client-care-related services or in quality assurance which is not available in the state of Texas; the purpose of delivering direct contracted client services within 25 miles of the Texas border with adjoining states or Mexico; or the purpose for the travel is to conduct business related to contracted client services in Texas and the travel is between Texas and the contracted provider's central office. All costs for travel outside the continental United States are unallowable costs, with the singular exception of travel required for the delivery of direct contracted client services within 25 miles of the Texas-Mexico border.

(iii) Expenses for private aircraft are allowable only if:

(I) written documentation supporting the calculations for expenses for private aircraft and commercial alternatives, and flight logs are maintained as specified in §355.105(b)(2)(B)(iii) of this title; and

(II) the documentation demonstrates that the expenses for travel via private aircraft were not greater than those for commercial alternatives at the time the travel took place. If the expenses for private aircraft were greater than the documented costs for commercial alternatives at the time the travel took place, allowable private aircraft costs are limited to the documented costs for commercial alternatives.

(13) Advertising and public relations.

(A) Allowable advertising and public relations include:

(i) costs of advertising to meet statutory or regulatory requirements, such as program standards, rules, or contract requirements;

(ii) informational listings of contracted providers in a telephone directory, including yellow page listings up to one-eighth of a page per telephone directory in the provider's service area or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry;

(iii) costs of advertising for the purpose of recruiting necessary personnel are allowable costs. Refer to the definition of necessary in §355.102(f)(2) of this title;

(iv) costs of advertising for procurement of items related to contracted client care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price; and

(v) costs of advertising incurred in connection with obtaining bids for construction or renovation of the contracted provider's facilities should be included in the capitalized cost of the asset. Refer to paragraph (7) of this subsection.

(B) Unallowable advertising and public relations include:

(i) costs of advertising of a general nature designed to invite physicians to utilize a contracted provider's facilities in their capacity as independent practitioners;

(ii) costs of advertising incurred in connection with the issuance of a contracted provider's own stock, or the sale of stock held by the contracted provider in another corporation considered as reductions in the proceeds from the sale;

(iii) costs of advertising to the general public which seeks to increase client utilization of the contracted provider's facilities;

(iv) public relations costs;

(v) any business promotional advertising; and

(vi) costs of the development of logos or other company identification.

(14) Promotional and fundraising activities. Promotional refers to any activity whose intent is to advertise or aid in the development of the business. Expenses relating to fundraising and promotional activities are unallowable, including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to these unallowable activities and as such not be reported on the cost report. Other expenses associated with these activities are also unallowable, including advertising, publicity, travel, and meals.

(15) Grants, gifts, and income from endowments and operating revenue.

(A) Restricted grants, gifts, and income from endowments from private sources used to purchase allowable program costs should not be deducted and offset from allowable costs prior to reporting on the cost report.

(B) Grants and contracts from federal, state or local government, such as transportation grants, United States Department of Agriculture grants, education grants, Housing and Urban Development grants, and Community Service Block Grants, should be offset, prior to reporting on the cost report, against the particular cost or group of costs for which the grant was intended. If federal funds are paid for the care of a specified client, those federal funds should not be offset prior to reporting on the cost report, unless otherwise specified in the program-specific reimbursement methodology rules.

(C) Unrestricted grants, gifts, and income from endowments from private sources used to purchase allowable program items should not be offset by the contracted provider prior to reporting on the cost report. All unrestricted funds which are properly allocable to the cost report should be reported on a contracted provider's cost report, as well as any allowable costs to which the unrestricted funds were applied.

(D) Nonroutine revenues such as income from operations not associated with providing contracted services, including, but not limited to, beauty and barber shops, vending machines, gift shops, canteen stores, and meals sold to employees or guests should be offset or reduced by the related expenses prior to reporting the revenue on the cost report. Expenses related to providing these types of non-contracted operations are unallowable costs. If nonroutine operating expenses, including overhead costs incurred to generate nonroutine operating revenue, exceed nonroutine operating revenues, the net nonroutine operating expenses are unallowable costs. Routine operating revenue received as payments for the contracted services, such as income from private clients, private room and board, or other sources of routine contracted services are not to be offset. Refer to §355.102(k) of this title for further guidelines on reporting net expenses.

(16) In-kind donations.

(A) Allowable in-kind donations.

(i) Depreciation of in-kind donations is limited to donated buildings and donated vehicles used in the direct provision of contracted client services, where title has been transferred to the provider entity by a third party in an arm's-length transaction. Depreciation must be reported in accordance with subsection (b)(7) of this section. The historical cost basis used to depreciate vehicles must be consistent with the retail price of the National Automobile Dealers Association (NADA) listings; or, in the case of a new vehicle, the documented historical cost to the donor or NADA may be used. The historical cost basis used to depreciate donated buildings must be the lower of:

(I) the most recent tax appraisal of the building prior to donation, unless the donor was exempt from tax appraisal, in which case an independent appraisal made by a third-party appraiser at the time of donation may be used in place of the tax appraisal (for donations made prior to the provider's 1997 fiscal year, a current appraisal from an independent third-party appraiser may be used to establish the historical cost); or

(II) the documented historical cost to the donor.

(ii) Expenses actually incurred to maintain a donated asset for use in providing contracted client care to clients are allowable.

(iii) If a provider receives a donation of the use of space owned by another organization and if the provider and the donor organization are both part of a larger organizational entity (such as units of a state or county government), the space is not considered a related-party donation, but rather treated as allowable costs requiring allocation between the provider and the other organization. For example, if a county home health agency is given space to use in the county office building, costs associated with the use of the space (such as depreciation, janitorial services, maintenance, and repairs) must be allocated from the county to the county home health agency. Allocation of costs must be in compliance with §355.102(j) of this title.

(B) Unallowable in-kind donations. The value of unallowable in-kind donations may be collected for specific programs at the discretion of HHSC for statistical purposes only, on a schedule separately identified for such purpose. The value of in-kind donations to a contracted provider, such as produce, supplies, materials, services, equipment, or other items used by the contracted provider which the contracted provider did not purchase, is an unallowable cost. The value of in-kind donations of buildings or vehicles when the title is not transferred to the provider is an unallowable cost. The value of in-kind donations to a contracted provider which are not arm's-length transactions are unallowable costs. The contracted provider may not treat as an allowable cost the imputed value for unallowable in-kind donations.

(17) Miscellaneous costs.

(A) Employee relations expenses. Costs relating to employee relations are different from fringe benefits, as specified in paragraph (1)(A)(iii) of this subsection, in that employee relations expenses incurred are for employees as a group rather than as a fringe benefit for an individual employee. Examples of allowable employee relations costs, which are reported as administrative costs for cost-reporting purposes, include a staff party, an employee outing, or other such staff expenses intended to boost employee morale and in turn increase the efficiency and quality of care provided. Other examples of allowable

employee relations expenses are plaques or awards presented to employees for certain achievements or honors. Employee relations cost which discriminates in favor of certain employees, such as employees who are officers, stockholders, related parties, or the highest paid individual(s) in the organization are unallowable. Employee relations costs are limited to a ceiling of $50 per employee eligible to participate per year. If a staff party includes nonemployees, an allocation must be made such that only the portion of costs relating to employees and their families in attendance is reported on the cost report. If a staff party also serves as an open house for promotional purposes, an allocation of costs must be made so that only costs relating to employees and their families in attendance are reported as allowable costs. Entertainment expenses other than those for the benefit of current clients or those for staff employee relations described above are unallowable costs.

(B) Organization costs. Organization costs are those costs directly incident to the creation of a corporation or other form of business necessary to provide contracted services. These costs are intangible assets in that they represent expenditures for rights and privileges which have a value to the business enterprise.

(i) Allowable organization costs include, but are not limited to, legal fees incurred (such as drafting documents) in establishing the corporation or other organization, necessary accounting fees, and fees paid to states for incorporation. Allowable organization costs must be amortized over a period of not less than 60 consecutive months, beginning with the first month in which services are delivered to the first client.

(ii) The following types of costs are considered unallowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, reorganization costs, and stockholder servicing costs. If the business or corporation never commences actual operations, the organization costs are unallowable.

(C) Franchise fees.

(i) Allowable franchise fees. Allowable franchise fees include those costs related to actual goods, supplies, and services received in return for fees paid to a company for the right to sell its goods and/or services in a specific territory.

(ii) Unallowable franchise fees. Franchise fees based upon percentages of revenues and/or sales are unallowable costs. Franchise fees based upon goodwill are unallowable, with goodwill being that intangible, salable asset arising from the reputation of a business and its relationship with its customers.

(D) Startup costs. Startup costs are those reasonable and necessary preparation costs incurred by a provider in the period of developing the provider's ability to deliver services. Startup costs can be incurred prior to the beginning of a newly-formed business and/or prior to the beginning of a new contract or program for an existing business. Allowable startup costs include, but are not limited to, employee salaries, utilities, rent, insurance, employee training costs, and any other allowable costs incident to the startup period. Startup costs do not include capital purchases, which are purchased assets meeting the criteria for depreciation in paragraph (7) of this subsection. Any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from startup costs. Allowable startup costs should be amortized over a period of not less than 60 consecutive months. If the business or corporation never commences actual operations or if the new contract/program never delivers services, the startup costs are unallowable.

(i) For a newly-formed business, startup costs should be accumulated up to the time the business begins (that is, when services are delivered to the first client/customer). Amortization of startup costs for a newly-formed business begins the month the business begins. In the event that a newly-formed business is established for the direct purpose of contracting with the state for delivery of client care services, startup costs should be accumulated up to the time the contract is effective or the time the first client receives services, whichever comes first, with amortization of startup costs beginning the same month.

(ii) For a new contract or program implemented by an existing business, startup costs are related only to the development of the provider's ability to furnish services according to the standards of the new contract/program and should be accumulated up to the time the first client receives services according to the contract/program standards or the effective date of the contract, whichever occurs first. Amortization of startup costs for a new contract/program implemented by an existing business begins the month in which the first client receives services according to contract/program standards or the effective date of the contract, whichever occurs first. If a contracted provider intends to prepare all portions of its entire program at the same time, startup costs for all portions of the program should be accumulated in a single account and should be amortized beginning either when the first client is admitted or the effective date of the contract, whichever occurs first. However, if a contracted provider intends to prepare portions of its program on a piecemeal basis, startup costs should be capitalized and amortized separately for the portion(s) of the provider's program prepared during different time periods. For example, a newly-formed corporation opens a senior citizen center for private clients, serving its first client on April 4, 1995. Startup costs would be those costs incurred prior to April 4, 1995, which meet the above definition of startup costs. Amortization of the startup costs for this newly-formed business would begin April 1995. If this same corporation received a contract to provide Day Activity and Health Services (DAHS) effective October 1, 1995 and if the corporation served its first DAHS client on November 5, 1995, startup costs would be those costs incurred to be able to deliver services according to DAHS program standards. If the corporation was in compliance with the DAHS standards from its beginning (April 1995), no new startup costs would be allowable for amortization as a result of the implementation of the new DAHS contract by the existing corporation. On the other hand, if the corporation was required to incur additional costs to bring the operation up to the DAHS program standards, those startup costs incurred prior to October 1, 1995 (since the contract effective date occurred prior to serving the first DAHS client) would be amortized beginning with October 1995.

(E) Research and development costs. Research and development costs, including, but not limited to, telephone costs, travel costs, attorney fees, and staff salaries, must be segregated into separate, individual accounts for each venture in the contracted provider's general ledger. Should such a "venture" result in a contract for a program, the allowable research and development costs would be incorporated as startup costs for that program. Research and development costs related to states other than Texas are not allowable costs for any allocation to any contracted program.

(F) Medical supplies and medical costs. In general, medical supplies and equipment required by the Occupational Safety and Health Administration (OSHA), used for universal health and safety precautions, or otherwise required to meet contracted program requirements are allowable costs. Refer to program-specific reimbursement methodology rules to determine program requirements for medical supplies and medical costs.

(G) Fines and penalties. Fines and penalties for violations of regulations, statutes, and ordinances of all types are unal-

lowable costs. Penalties or charges for late payment of taxes, utilities, mortgages, loans or insufficient banking funds are unallowable costs.

(H) Business expenses not directly related to contracted services. Business expenses not directly related to contracted services, including business investment activities, stockholder and public relations activities, and farm and ranch operations (unless farm and ranch operations are specifically allowed by the contracted program as necessary to the provision of client care), are unallowable costs.

(I) Litigation expenses and awards. Unless explicitly allowed elsewhere in this chapter, no court-ordered award of damages or settlements made in lieu thereof or legal fees associated with litigation which resulted in any court-ordered award of damages or settlements made in lieu thereof, or a criminal conviction, are allowable. For workers' compensation litigation awards and settlements, the part of the award or settlement that reimburses the injured employee for lost wages and medical bills is an allowable cost.

(J) Lobbying costs. Lobbying costs are unallowable.

(i) Lobbying means the influencing or attempting to influence an officer or employee of any governmental agency, an officer or employee of Congress or the state legislature, or an employee of a member of Congress or the state legislature in connection with any of the following actions:

(I) the awarding of any governmental contract;

(II) the making of any governmental grant;

(III) the making of any governmental loan;

(IV) the entering of any cooperative agreement; and

(V) the extension, continuation, renewal, amendment, or modification of any governmental contract, grant, loan or cooperative agreement.

(ii) Costs associated with the following activities are unallowable as lobbying costs:

(I) attempting to influence the outcomes of any governmental election, referendum, initiative, or similar procedure, through in-kind or cash contributions, endorsements, publicity, or similar activity;

(II) establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(III) attempting to influence the introduction of governmental legislation, the enactment or modification of any pending governmental legislation through communication with any member or employee of the Congress or state legislature (including efforts to influence state or local officials to engage in similar lobbying activity) or any governmental official or employee in connection with a decision to sign or veto enrolled legislation;

(IV) attempting to influence the introduction of governmental legislation, or the enactment or modification of any pending governmental legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public, or any segment thereof, to contribute to or participate in any mass demonstration, march, rally, fund raising drive, lobbying campaign or letter writing or telephone campaign; and

(V) performing legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

(iii) The cost to contracted providers or their staff to attend meetings with the staff of state agencies or to attend public hearings or advisory committee meetings held by state agencies that are involved in the regulation of contracted client care in the program with which they are contracting and which meetings do not meet the definition of lobbying stated above, are not considered lobbying and are therefore allowable costs.

(iv) Expenses relating to lobbying are unallowable including salaries, benefits, and payroll taxes for staff performing these activities. If a staff member performs these activities along with allowable activities, a portion of that staff member's salary must be allocated to the unallowable activities and as such not be reported on the cost report.

(K) Direct reimbursements. Unless specifically exempted through program-specific reimbursement methodology rules, HHSC procedures or cost report instructions, any expenses directly reimbursable to the contracted provider that are considered outside the reimbursement payment system are unallowable costs. Such expenses include but are not limited to those associated with Medicare Part A and B ancillary services, HHSC voucher payment systems and vendor drug coverage. For guidelines on allowability of reporting costs in excess of those reimbursable directly through a voucher payment system, refer to program-specific reimbursement methodology rules.

(L) Losses resulting from theft or embezzlement. Losses resulting from theft or embezzlement of property or funds of the contracted provider or clients by the owners or employees of the contracted provider are not allowable costs.

(M) A bad debt. A bad debt allowance is a reduction in revenue resulting from unrecoverable revenue in uncollectible accounts created or acquired in the provision of contracted client care. Bad debt as an expense is unallowable.

(N) A charity or courtesy allowance. A charity allowance is a reduction in normal charges due to the indigence of the client or resident. A courtesy allowance is a reduction in charges granted as a courtesy to certain individuals, such as physicians or clergy. These allowances themselves are not costs since the costs of the services rendered are already included in the contracted provider's costs.

(18) Medicaid as payor of last resort. Medicaid is the payor of last resort. If a recipient has Medicare Part A or B benefits, other third party payor benefits, or any other benefits available those benefits must be accessed before Medicaid.

(19) For any individual eligible for Medicare Part D, the cost of any drug that is in a category that is covered by Medicare Part D is unallowable.

§355.105. General Reporting and Documentation Requirements, Methods, and Procedures.

(a) General reporting. Except where otherwise specified under this title, the Texas Health and Human Services Commission (HHSC) follows the requirements, methods, and procedures set forth in subsections (b) - (h) of this section to determine costs appropriate for use in the reimbursement determination process.

(b) Cost report requirements. Unless specifically stated in program rules, each provider must submit financial and statistical information on cost report forms provided by HHSC, or on facsimiles that are formatted according to HHSC specifications and are pre-approved by HHSC staff, or electronically in HHSC-prescribed format in programs

where these systems are operational. The cost reports must be submitted to HHSC in a manner prescribed by HHSC. The cost reports must be prepared to reflect the activities of the provider while delivering contracted services during the fiscal year specified by the cost report. Cost reports or other special surveys or reports may be required for other periods at the discretion of HHSC. Each provider is responsible for accurately completing any cost report or other special survey or report submitted to HHSC.

(1) Accounting methods. All financial and statistical information submitted on cost reports must be based upon the accrual method of accounting, except where otherwise specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) and in the case of governmental entities operating on a cash or modified accrual basis. For cost-reporting purposes, accrued expenses must be incurred during the cost reporting period and must be paid within 180 days after the end of that cost reporting period. In situations where a contracted provider, any of its controlling entities, its parent company/sole member, or its related-party management company has filed for bankruptcy protection, the contracted provider may request an exception to the 180-day requirement for payment of accrued allowable expenses by submitting a written request to the HHSC Rate Analysis Department. The written request must be submitted within 60 days of the date of the bankruptcy filing or at least 60 days prior to the due date of the cost report for which the exception is being requested, whichever is later. The contracted provider will then be requested by the HHSC Rate Analysis Department to provide certain documentation, which must be provided by the specified due date. Such exceptions due to bankruptcy may be granted for reasonable, necessary and documented accrued allowable expenses that were not paid within the 180-day requirement. Accrued revenues must be for services performed during the cost reporting period and do not have to be received within 180 days after the end of that cost reporting period in order to be reported as revenues for cost-reporting purposes. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost reporting rules differ from GAAP, IRS, or other authorities, HHSC rules take precedence for provider cost-reporting purposes.

(2) Recordkeeping and adequate documentation. There is a distinction between noncompliance in recordkeeping, which equates with unauditability of a cost report and constitutes an administrative contract violation or, for the Nursing Facility program, may result in vendor hold, and a provider's inability to provide adequate documentation, which results in disallowance of relevant costs. Each is discussed in the following paragraphs.

(A) Recordkeeping. Providers must ensure that records are accurate and sufficiently detailed to support the legal, financial, and other statistical information contained in the cost report. Providers must maintain all workpapers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys, and schedules. HHSC may require supporting documentation other than that contained in the cost report to substantiate reported information.

(i) For Texas Department of Aging and Disability Services (DADS) - contracted providers, each provider must maintain records according to the requirements stated in 40 TAC §69.158 (relating to How long must contractors, subrecipients, and subcontractors keep contract-related records?) and according to the HHSC's prescribed chart of accounts, when available.

(ii) If a contractor is terminating business operations, the contractor must ensure that:

(I) records are stored and accessible; and

(II) someone is responsible for adequately maintaining the records.

(iii) For nursing facilities, failure to maintain all workpapers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys and schedules may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(iv) For all other programs, failure to maintain all workpapers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys and schedules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

(B) Adequate documentation. To be allowable, the relationship between reported costs and contracted services must be clearly and adequately documented. Adequate documentation consists of all materials necessary to demonstrate the relationship of personnel, supplies, and services to the provision of contracted client care or the relationship of the central office to the individual service delivery entity level. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by HHSC auditors to perform required tests of reasonableness, necessity, and allowability.

(i) The minimum allowable statistical duration for a time study upon which to base salary allocations is four weeks per year, with one week being randomly selected from each quarter so as to assure that the time study is representative of the various cycles of business operations. One week is defined as only those days the contracted provider is in operation during seven continuous days. The time study can be performed for one continuous week during a quarter, or it can be performed over five or seven individual days, whichever is applicable, throughout a quarter. The time study must be a 100% time study, accounting for 100% of the time paid the employee, including vacation and sick leave.

(ii) To support the existence of a loan, the provider must have available a signed copy of the loan contract which contains the pertinent terms of the loan, such as amount, rate of interest, method of payment, due date, and collateral. The documentation must include an explanation for the purpose of the loan and an audit trail must be provided showing the use of the loan proceeds. Evidence of systematic interest and principal payments must be available and supported by the payback schedule in the note or amortization schedule supporting the note. Documentation must also include substantiation of any costs associated with the securing of the loan, such as broker's fees, due diligence fees, lender's fees, attorney's fees, etc. To document allowable interest costs associated with related party loans, the provider is required to maintain documentation verifying the prime interest rate in accordance with §355.103(b)(8)(C) of this title for a similar type of loan as of the effective date of the related party loan.

(iii) For ground transportation equipment, a mileage log is not required if the equipment is used solely (100%) for provision of contracted client services in accordance with program requirements

in delivering one type of contracted care. However, the contracted provider must have a written policy that states that the ground transportation equipment is restricted to that use and that policy must be followed. For ground transportation equipment that is used for several purposes (including for personal use) or multiple programs or across various business components, mileage logs must be maintained. Personal use includes, among other things, driving to and from a personal residence. At a minimum, mileage logs must include for each individual trip the date, the time of day (beginning and ending), driver, persons in the vehicle, trip mileage (beginning, ending, and total), purpose of the trip, and the allocation centers (the departments, programs, and/or business entities to which the trip costs should be allocated). Flight logs must include dates, mileage, passenger lists, and destinations, along with any other information demonstrating the purpose of the trips so that a relationship to contracted client care in Texas can be determined. For the purpose of comparison to the cost of commercial alternatives, documentation of the cost of operating and maintaining a private aircraft includes allowable expenses relating to the lease or depreciation of the aircraft; aircraft fuel and maintenance expenses; aircraft insurance, taxes, and interest; pilot expenses; hangar and other related expenses; mileage, vehicle rental or other ground transportation expense; and airport parking fees. Documentation demonstrating the allowable cost of commercial alternatives includes commercial airfare ticket costs at lowest fare offered (including all discounts) and associated expenses including mileage, vehicle rental or other ground transportation expense; airport parking fees; and any hotel or per diem due to necessary layovers (no scheduled flights at time of return trip).

(iv) To substantiate the allowable cost of leasing a luxury vehicle as defined in §355.103(b)(7)(C)(i) of this title, the provider must obtain at the time of the lease a separate quotation establishing the monthly lease costs for the base amount allowable for cost-reporting purposes as specified in §355.103(b)(7)(C)(i) of this title. Without adequate documentation to verify the allowable lease costs of the luxury vehicle, the reported costs shall be disallowed.

(v) For adequate documentation purposes, a written description of each cost allocation method must be maintained that includes, at a minimum, a clear and understandable explanation of the numerator and denominator of the allocation ratio described in words and in numbers, as well as a written explanation of how and to which specific business components the remaining percentage of costs were allocated.

(vi) To substantiate the allowable cost for staff training as defined in §355.103(b)(12)(A) of this title, the provider must maintain a description of the training verifying that the training pertained to contracted client care-related services or quality assurance. At a minimum, a program brochure describing the seminar or a conference program with description of the workshop must be maintained. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training pertaining to contracted client care-related services or quality assurance.

(vii) Documentation regarding the allocation of costs related to noncontracted services, as specified in §355.102(j)(2) of this title, must be maintained by the provider. At a minimum, the provider must maintain written records verifying the number of units of noncontracted services provided during the provider's fiscal year, along with adequate documentation supporting the direct and allocated costs associated with those noncontracted services.

(viii) Adequate documentation to substantiate legal, accounting, and auditing fees must include, at a minimum, the amount of time spent on the activity, a written description of the activity performed which clearly explains to which business component the cost should be allocated, the person performing the activity, and the hourly billing amount of the person performing the activity. Other legal, accounting, and auditing costs, such as photocopy costs, telephone costs, court costs, mailing costs, expert witness costs, travel costs, and court reporter costs, must be itemized and clearly denote to which business component the cost should be allocated.

(ix) Providers who self insure for all or part of their employee-related insurance costs, such as health insurance and workers' compensation costs, must use one of the two following methods for determining and documenting the provider's allowable costs under the cost ceilings and any carry forward as described in §355.103(b)(10)(E) of this title.

(I) Providers may obtain and maintain each fiscal year's documentation to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years.

(II) If providers choose not to obtain and maintain commercial bids as described in subclause (I) of this clause, providers may claim as an allowable cost the health insurance actual paid claims incurred on behalf of the employees that does not exceed 10% of the payroll for employees eligible for receipt of this benefit. In addition, providers may claim as an allowable cost the workers' compensation actual paid claims incurred on behalf of the employees, an amount each cost report period not to exceed 10% of the payroll for employees eligible for receipt of this benefit.

(III) Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

(x) Providers who self insure for all or part of their coverage for nonemployee-related insurance, such as malpractice insurance, comprehensive general liability, and property insurance, must maintain documentation for each cost-reporting period to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years. Providers who self insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods. Governmental providers must document the existence of their claims management and risk management programs.

(xi) Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party: a detailed written description of actual duties, functions, and responsibilities; documentation substantiating that the services performed are not duplicative of services performed by other employees; time sheets or other documentation verifying the hours and days worked; the amount of total compensation paid for these duties, with a breakdown detailing regular salary, overtime, bonuses, benefits, and other payments; documentation of regular, periodic payments and/or accruals of the compensation, documentation that the compensation is subject to payroll or self-employment taxes; and a detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

(I) Regarding bonuses paid to owners and related parties, the provider must maintain clearly defined bonus policies in its written agreements with employees or in its overall employment policy. At a minimum, the bonus policy must include the basis for distributing

the bonuses including qualifications for receiving the bonus, and how the amount of each bonus is calculated. Other documentation must specify who received bonuses, whether the persons receiving bonuses are owners, related parties, or arm's-length employees, and the bonus amount received by each individual.

(II) Regarding benefits provided to owners and related parties, the provider must maintain clearly defined benefit policies in its written agreements with employees or in its overall employment policy. At a minimum, the documentation must include the basis for eligibility for each type of benefit available, who is eligible to receive each type of benefit, who actually receives each type of benefit, whether the persons receiving each type of benefit are owners, related parties, or arm's-length employees, and the amount of each benefit received by each individual.

(xii) Regarding all forms of compensation, providers must maintain documentation for each employee which clearly identifies each compensation component, including regular pay, overtime pay, incentive pay, mileage reimbursements, bonuses, sick leave, vacation, other paid leave, deferred compensation, retirement contributions, provider-paid instructional courses, health insurance, disability insurance, life insurance, and any other form of compensation. Types of documentation would include insurance policies; provider benefit policies; records showing paid leave accrued and taken; documentation to support hours (regular and overtime) worked and wages paid; and mileage logs or other documentation to support mileage reimbursements and travel allowances. For accrued benefits, the documentation must clearly identify the period of the accrual. For example, if an employee accrues two weeks of vacation during 20x1 and receives the corresponding vacation pay during 20x3, that employee's compensation documentation for 20x3 should clearly indicate that the vacation pay received had been accrued during 20x1.

(I) For staff required to maintain continuous daily time sheets as per §355.102(j) of this title and subclause (II) of this clause, the daily timesheet must document, for each day, the staff member's start time, stop time, total hours worked, and the actual time worked (in increments of 30 minutes or less) providing direct services for the provider, the actual time worked performing other functions, and paid time off. The employee must sign each timesheet. The employee's supervisor must sign the timesheets each payroll period or at least monthly. Work schedules are unacceptable documentation for staff whose duties include multiple direct service types, both direct and indirect service component types, and both direct hands-on support and first level supervision of direct care workers.

(II) For the Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services and Texas Home Living programs, staff required to maintain continuous daily timesheets include staff whose duties include multiple direct service types, both direct and indirect service component types and/or both direct hands-on support and first-level supervision of direct care workers.

(xiii) Management fees paid to related parties must be documented as to the actual costs of the related party for materials, supplies, and services provided to the individual provider, and upon which the management fees were based. If the cost to the related party includes owner compensation or compensation to related parties, documentation guidelines for those costs are specified in clause (xi) of this subparagraph. Documentation must be maintained that indicates stated objectives, periodic assessment of those objectives, and evaluation of the progress toward those objectives.

(xiv) For central office and/or home office costs, documentation must be maintained that indicates the organization of the business entity, including position, titles, functions, and compensation. For multi-state organizations, documentation must be maintained that clearly defines the relationship of costs associated with any level of management above the individual Texas contracted entity which are allocated to the individual Texas contracted entity.

(xv) Documentation regarding depreciable assets includes, at a minimum, historical cost, date of purchase, depreciable basis, estimated useful life, accumulated depreciation, and the calculation of gains and losses upon disposal.

(xvi) Providers must maintain documentation clearly itemizing their employee relations expenditures. For employee entertainment expenses, documentation must show the names of all persons participating, along with classification of the person attending, such as employee, nonemployee, owner, family of employee, client, or vendor.

(xvii) Adequate documentation substantiating the offsetting of grants and contracts from federal, state, or local governments prior to reporting either the net expenses or net revenue must be maintained by the provider. As specified in §355.103(b)(15) of this title, such offsetting is required prior to reporting on the cost report. The provider must maintain written documentation as to the purpose for which the restricted revenue was received and the offsetting of the restricted revenue against the allowable and unallowable costs for which the restricted revenue was used.

(xviii) During the course of an audit or an audit desk review, the provider must furnish any reasonable documentation requested by HHSC auditors within ten working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or audit desk review is closed, and HHSC automatically disallows the costs in question.

(xix) Any expense that cannot be adequately documented or substantiated is disallowed. HHSC is not responsible for the contracted provider's failure to adequately document and substantiate reported costs.

(xx) Any cost report that is determined unauditable through a field audit or that cannot have its costs verified through a desk review will not be used in the reimbursement determination process.

(3) Cost report and methodology certification. Providers must certify the accuracy of cost reports submitted to HHSC in the format specified by HHSC. Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to HHSC requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they read the cost determination process rules, the reimbursement methodology rules, the cost report cover letter and cost report instructions, and that they understand that the cost report must be prepared in accordance with the cost determination process rules, the reimbursement methodology rules and cost report instructions. Not all persons who contributed to the completion of the cost report must sign the certification page. However, the certification page must be signed by a responsible party with direct knowledge of the preparation of the cost report. A person with supervisory authority over the preparation of the cost report who reviewed the completed cost report may sign a certification page in addition to the actual preparer.

(4) Requirements for cost report completion.

(A) A completed cost report must:

(i) be completed according to the cost determination rules of this chapter, program-specific allowable and unallowable rules, cost report instructions, and policy clarifications;

(ii) contain a signed, notarized, original certification page or an electronic equivalent where such equivalents are specifically allowed under HHSC policies and procedures;

(iii) be legible with entries in sufficiently dark print to be photocopied;

(iv) contain all pages and schedules;

(v) be submitted on the proper cost report form;

(vi) be completed using the correct cost reporting period; and

(vii) contain a copy of the state-issued cost report training certificate except for cost reports submitted through the State of Texas Automated Information and Reporting System (STAIRS).

(B) Providers are required to report amounts on the appropriate line items of the cost report pursuant to guidelines established in the methodology rules, cost report instructions, [~~and/~~]or policy clarifications. Refer to program-specific reimbursement methodology rules, cost report instructions, [~~and/~~]or policy clarifications for guidelines used to determine placement of amounts on cost report line items.

(i) For nursing facilities, placement on the cost report of an amount, which was determined to be inaccurately placed, may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(ii) For School Health and Related Services (SHARS), placement on the cost report of an amount, which was determined to be inaccurately placed, may result in an administrative contract violation as specified in §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)).

(iii) [~~(ii)~~] For all other programs, placement on the cost report of an amount, which was determined to be inaccurately placed, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(C) A completed cost report must be filed by the cost report due date.

(i) For nursing facilities, failure to file a completed cost report by the cost report due date may result in vendor hold as specified in §355.403 of this title.

(ii) For SHARS, failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this title.

(iii) [~~(ii)~~] For all other programs, failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(D) HHSC may excuse providers from the requirement to submit a cost report. Exceptions are granted by HHSC as described by the program-specific reimbursement methodology rules. Providers who are excused from cost report submission will receive written notice from HHSC verifying that an exception has been granted.

(5) Cost report year. A provider's cost report year must coincide with the provider's fiscal year as used by the provider for reports to the Internal Revenue Service (IRS) or with the state of Texas' fiscal year, which begins September 1 and ends August 31.

(A) Providers whose cost report year coincides with their IRS fiscal year are responsible for reporting to HHSC Rate Analysis any change in their IRS fiscal year and subsequent cost report year by submitting written notification of the change to HHSC Rate Analysis along with supportive IRS documentation. HHSC Rate Analysis must be notified of the provider's change in IRS fiscal year no later than 30 days following the provider's receipt of approval of the change from the IRS.

(B) Providers who chose to change their cost report year from their IRS fiscal year to the state fiscal year or from the state fiscal year to their IRS fiscal year must submit a written request to HHSC Rate Analysis by August 1 of state fiscal year in question.

(6) Failure to report allowable costs. HHSC is not responsible for the contracted provider's failure to report allowable costs, however any omitted costs which are identified during the desk review or audit process will be included in the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(c) Cost report due date.

(1) Providers must submit cost reports to HHSC Rate Analysis no later than 90 days following the end of the provider entity's fiscal year or 90 days from the transmittal date of the cost report forms, whichever due date is later. For SHARS, providers must submit cost reports to HHSC Rate Analysis as specified in §355.8443 of this title.

(2) HHSC may grant extensions of due dates for good cause. A good cause is defined as a circumstance which the provider could not reasonably be expected to control and for which adequate advance planning and organization would not have been of any assistance. Providers must submit requests for extensions in writing to HHSC Rate Analysis. Requests for extensions must be received by HHSC Rate Analysis prior to the cost report due date. HHSC staff will respond in writing to requests within 15 days of receipt.

(3) HHSC may require additional financial and other statistical information, in the form of special surveys or reports, to ensure the fiscal integrity of the program. Providers must submit such additional information and/or special surveys or reports to HHSC Rate Analysis upon request by the date specified by HHSC Rate Analysis in its transmittal or cover letter to the special survey, report, or request for additional information.

(d) Amended cost report due dates. HHSC accepts submittal of provider-initiated or HHSC-requested amended cost reports as follows.

(1) Provider-initiated amended cost reports must be received no later than the date in subparagraph (A) or (B) of this paragraph, whichever occurs first. Amended cost reports received after the required date have no effect on the reimbursement determination. Amended cost report information that cannot be verified will not be used in reimbursement determinations. Provider-initiated amended cost reports must be received no later than the earlier of:

(A) 60 days after the original due date of the cost report; or

(B) 30 days prior to the public hearing on proposed reimbursement or reimbursement parameter amounts.

(2) HHSC-required amendments to the cost reports must be received on or before the date specified by HHSC in its request for the amended cost report. Failure to submit the requested amendment to the cost report by the due date is considered a failure to complete a cost report as specified in subsection (b)(4)(C) of this section.

(e) Field audit standards. HHSC performs cost report field audits in a manner consistent with Government Auditing Standards issued by the Comptroller General of the United States.

(f) Cost of out-of-state audits. As specified in §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), HHSC conducts desk reviews of all cost reports not selected for field audit. HHSC also conducts field audits of provider records and cost reports. Although the number of field audits performed each year may vary, HHSC seeks to maximize the number of field audited cost reports available for use in its cost projections. Whenever possible, all the records necessary to verify information submitted to HHSC on cost reports, including related party transactions and other business activities engaged in by the provider, must be accessible to HHSC audit staff within the state of Texas within fifteen working days of field audit or desk review notification. When records are not available to HHSC audit staff within the state of Texas, the provider must pay the actual costs for HHSC staff to travel and review the records out-of-state. HHSC must be reimbursed for these costs within 60 days of the request for payment.

(1) For nursing facilities, failure to reimburse HHSC for these costs within 60 days of the request for payment may result in vendor hold as specified in §355.403 of this title.

(2) For SHARS, failure to reimburse HHSC for these costs within 60 days of the request for payment constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this title.

(3) [~~(2)~~] For all other programs, failure to reimburse HHSC for these costs within 60 days of the request for payment constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(g) Public hearings.

(1) Uniform reimbursements. For programs where reimbursements are uniform by class of service and/or provider type, HHSC will hold a public hearing on proposed reimbursements before HHSC approves reimbursements. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed reimbursements. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursements. At least ten working days before the public hearing takes place, material pertinent to the proposed statewide uniform reimbursements will be made available to the public. This material will include the proposed reimbursements, the inflation adjustments used to determine them, and the impact on reimbursements of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a summary of the comments made during the public hearing will be presented to HHSC.

(2) Contractor-specific reimbursements. For programs in which reimbursements are contractor-specific, HHSC will hold a public hearing on the reimbursement determination parameter dollar amounts (e.g., ceilings, floors, or program reimbursement formula limits) before HHSC approves parameter dollar amounts. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed reimbursement parameter dollar amounts. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursement parameter dollar amounts. At least ten working days before the public hearing takes place, material pertinent to the proposed reimbursement parameter dollar amounts will be made available to the public. This material will include the proposed reimbursement parameter dollar amounts, the inflation adjustments used to determine them, and the impact on the reimbursement parameter dollar amounts of the major cost limits. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a summary of the comments made during the public hearing will be presented to HHSC.

(h) Insufficient cost data. If an insufficient number of accurate, full-year cost reports is submitted, as would occur with a new program, or if there are insufficient available data, as would occur in changes in program design, changes in the definition of units of service or changes in regulations or program requirements, reimbursements may be based on a pro-forma analysis by HHSC staff. A pro-forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate. The analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses. To determine the cost per unit of service, HHSC adds all the pro-forma expenses and divides the total by the estimated number of units of service that a fully operational provider is likely to provide. The pro-forma analysis is based on available information that is determined to be sufficient, accurate, and reliable by HHSC, including valid cost report data and survey data. The pro-forma analysis is conducted in a way that ensures that the resultant reimbursements are sufficient to support the requirements of the contracted program. When HHSC staff determine that sufficient and reliable cost report data have become available, the pro-forma reimbursement determination may be replaced with a process based on cost reports.

(i) Limits on related-party salaries, wages and/or benefits. HHSC may place upper limits or caps on related-party salaries, wages, and/or benefits as follows:

(1) For related-party administrators and directors, the upper limit for salaries and wages is equal to the 90th percentile in the array of all non-related party annualized salaries, wages and/or benefits as reported by all contracted providers within a program. In addition, the hourly wage and/or benefits for related-party administrators and directors is limited to the annualized upper limit for related-party administrators and directors divided by 2,080.

(2) For related-party assistant administrators and assistant directors, the upper limit for salaries and wages is equal to the 90th percentile in the array of all non-related party annualized salaries, wages and/or benefits as reported by all contracted providers within a program. In addition, the hourly wage and/or benefits for related-party assistant administrators and assistant directors is limited to the annualized upper limit for related-party assistant administrators and assistant directors divided by 2,080.

(3) For owners, partners, and stockholders (when the owner, partner, or stockholder is performing contract level administrative functions but is not the administrator, director, assistant administrator or assistant director), the upper limits for salaries and wages are equal to the upper limits for related-party administrators and directors.

(4) For all other staff types:

(A) For the Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services and Texas Home Living programs, related-party limitations are specified in §355.457 of this title (relating to Cost Finding Methodology [~~Fiscal Accountability~~]), and §355.722 of this title (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

(B) For all other programs, related-party salaries, wages and/or benefits are limited to reasonable and necessary costs as described in §355.102 of this title.

§355.106. Basic Objectives and Criteria for Audit and Desk Review of Cost Reports.

(a) The Texas Health and Human Services Commission (HHSC) conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. Cost reports must be completed according to instructions and rules in accordance with §355.105(b)(4) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). HHSC may require supporting documentation other than that contained in the cost report to substantiate reported information.

(1) For nursing facilities, failure to complete cost reports according to instructions and rules in accordance with §355.105(b)(4) of this title may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(2) For Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, failure to complete cost reports according to instructions and rules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

(3) For School and Health Related Services (SHARS), failure to complete cost reports according to instructions and rules described in §355.105(b)(4) of this title may result in an administrative contract violation as specified in §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)).

(4) [~~(3)~~] For all other programs, failure to complete cost reports according to instructions and rules in accordance with §355.105(b)(4) of this title constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(b) The basic objective of audits and desk reviews is to verify that each provider's cost report:

(1) displays financial and other statistical information in the format required by HHSC;

(2) reports expenses in conformity with HHSC's lists of allowable and unallowable costs;

(3) follows generally accepted accounting principles, except as otherwise specified in HHSC's lists of allowable and unallowable costs, and other pertinent rules or as otherwise permitted in the case of governmental entities operating on a cash or modified accrual basis; and

(4) is completed in accordance with each program's cost report instructions and rules.

(c) HHSC verifies the information specified in subsection (b) of this section by:

(1) comparing each provider's reported costs to:

(A) past patterns of expenditures for similar services;

(B) the results of previous field audits;

(C) normal operating cost relationships; and

(D) industry average costs, when available;

(2) reviewing each provider's reported costs for:

(A) reported unallowable costs;

(B) omitted allowable costs, if discovered during the course of the audit or desk review; and

(C) understated or overstated allowable costs, if discovered during the course of the audit or desk review;

(3) checking for completion of required information;

(4) checking the format for proper cost classification;

(5) checking for mathematical accuracy; and

(6) adjusting the cost report, or notifying the provider that research and/or corrections are required.

(d) In accordance with methodology rules, cost report instructions or policy clarifications, HHSC may reassign allowable costs to the appropriate line items of a cost report.

(e) HHSC seeks to maximize the number of field audited cost reports available for use in its cost projections. In addition to cost reports selected for field audit based upon risk analysis, other specific criteria and random sampling, HHSC may conduct field audits of cost reports that show unusual fluctuations or trends in costs or other statistics. HHSC may also conduct field audits when desk reviews are insufficient to verify the accuracy of reported costs.

(f) For cost reports pertaining to providers' fiscal years ending in calendar year 1997 and subsequent years, each provider entity or its designated agent(s) must allow access to any and all records necessary to verify information submitted to HHSC on cost reports. This requirement includes records pertaining to related party transactions or other business activities engaged in by the provider.

(1) For nursing facilities, failure to allow access to any and all records necessary to verify information submitted to HHSC on cost reports may result in vendor hold as specified in §355.403 of this title [~~(relating to Vendor Hold)~~].

(2) For Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-based Services, Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living programs, failure to allow access to any and all records necessary to verify information submitted to HHSC on cost reports constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS, failure to allow access to any and all records necessary to verify information submitted to HHSC on cost reports may result in an administrative contract violation as specified in §355.8443 of this title.

(4) [~~(3)~~] For all other programs, failure to allow access to any and all records necessary to verify information submitted to HHSC on cost reports constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(g) A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance in accordance with §355.110 of this title (relating to Informal Reviews and Formal Appeals).

§355.107. Notification of Exclusions and Adjustments.

(a) The Texas Health and Human Services Commission (HHSC) notifies providers of exclusions and adjustments to reported expenses made during HHSC's desk reviews and field audits of cost reports. HHSC mails notices of desk-review exclusions and adjustments within 15 working days after finalization of the desk-review by HHSC auditors. The notice consists of a letter to the provider and desk-review adjustment sheet(s), or an e-mail notification to the provider and online access to view the cost report adjustments, that specifies:

(1) the line-items on the cost report that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(b) HHSC also furnishes providers with written reports of the results of field audits. HHSC mails each field audit report within 30 days after the final exit interview with the provider. An exit interview is final when HHSC audit staff have received, reviewed, and analyzed all documentation from the provider pertinent to the scope of the audit. The field audit report consists of a professional report prepared by HHSC audit staff to enumerate the results of a field audit. Each field audit report includes a specification of:

(1) cost report line-items that have been adjusted or excluded;

(2) the amount of each adjustment or exclusion; and

(3) the principal reason for each adjustment or exclusion.

(c) A provider may also submit a written request for HHSC to provide additional information about exceptions and adjustments to the provider's cost report, including citations of the laws or regulations that constitute the grounds for the exceptions and adjustments. HHSC must comply with such requests in writing within 30 calendar days.

§355.110. Informal Reviews and Formal Appeals.

(a) General provisions.

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

(A) Formal appeal--An administrative hearing requested by an interested party under subsection (d) of this section and conducted in accordance with procedures described at §§357.481 - 357.498 of this title (relating to Hearings Under the Administrative Procedure Act).

(B) Informal review--The informal reexamination of an action or determination by the Texas Health and Human Services Commission (HHSC) under this chapter requested by an interested party and conducted in accordance with subsection (c) of this section.

(C) Interested party--An HHSC Enterprise [~~A Texas Department of Aging and Disability Services (DADS)~~] contracted or enrolled provider.

(2) Standing to file informal reviews or formal appeals. Only an interested party has standing to file for an informal review or formal appeal under this section.

(3) Subject matter of informal reviews and formal appeals. An interested party may request an informal review or formal appeal regarding an action or determination under §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this title (relating to Revenues), and §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures), or program-specific allowable or unallowable costs, taken specifically in regard to the interested party.

(b) Separation of informal reviews and formal appeals from the reimbursement determination process.

(1) The filing of a request for an informal review or formal appeal under this section does not stay or delay implementation of reimbursement adopted by HHSC in accordance with the requirements of this chapter.

(2) Closure of cost report databases used in the reimbursement determination process and application of results of pending review or appeal. To facilitate the timely and efficient calculation of reimbursement amounts, HHSC closes cost report databases used in the reimbursement determination process prior to the proposal of reimbursement amounts.

(A) Impact on database of pending informal review or formal appeal. If an informal review is pending at the time the database is closed, the database shall include the interested party's cost report data including any adjustments made either in the desk review or field audit. If a formal appeal is pending at the time the database is closed, the database shall include the interested party's cost report data including any adjustments required as a result of the informal review.

(B) Uniform reimbursement.

(i) For programs where reimbursement is uniform by class of service and/or provider type, the cost report database used in reimbursement determination is closed six weeks prior to the public hearing on the proposed reimbursement that is based on the cost report database.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied during the next reimbursement determination cycle, if applicable.

(C) Contractor-specific reimbursement.

(i) For programs where reimbursement is contractor-specific the cost report database is closed ten weeks prior to the end of the reimbursement determination cycle.

(ii) If an informal review or formal appeal is pending at the time the cost report database is closed, the results of the informal review or formal appeal shall be applied to the interested party's payment retroactively to the beginning of the current reimbursement determination cycle. The results of the informal review or formal appeal shall not be applied to the cost report database as a whole or to any other reimbursement amounts influenced by the cost report database as a whole until the next reimbursement determination cycle, if applicable.

(c) Informal review.

(1) An interested party who disputes an action or determination under this chapter may request an informal review under this section. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute. An informal review is not a formal administrative hearing, but is a prerequisite to obtaining a formal administrative hearing and is conducted according to the following procedures:

(A) HHSC Rate Analysis must receive a written request for an informal review by hand delivery, United States (U.S.) mail, or special mail delivery no later than 30 calendar days from the date on the written notification of the adjustments. If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day the receipt of the written request will be accepted. HHSC Rate Analysis will extend this deadline if it receives a written request for the extension by hand delivery, U.S. mail, or special mail delivery no later than 30 calendar days from the date of the written notice of adjustments. The extension gives the requester a total of 45 calendar days from the date of the written notice of adjustment to file a request for an informal review. If the 45th calendar day is a weekend day, national holiday, or state holiday, then the 45th day is considered the next business day following the 45th calendar day. A request for an informal review or extension that is not received by the stated deadline will not be accepted.

(B) An interested party must, with its request for an informal review, submit a concise statement of the specific actions or determinations it disputes, its recommended resolution, and any supporting documentation the interested party deems relevant to the dispute. It is the responsibility of the interested party to render all pertinent information at the time of its request for an informal review. A request for an informal review that does not meet the requirements of this subparagraph will not be accepted.

(C) The written request for the informal review or extension must be signed by an individual legally responsible for the conduct of the interested party, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable HHSC Enterprise or Texas Medicaid and Healthcare Partnership (TMHP) signature authority designation form [~~DADS Form~~ 2031] for the interested party on file at the time of the request, or a legal representative for the interested party. The administrator or director of the facility or program is not authorized to sign the request unless the administrator or director holds one of these positions. A request for an informal review that is not signed by an individual legally responsible for the conduct of the interested party will not be accepted.

(2) On receipt of a request for informal review:

(A) The lead staff member coordinates the review of the information submitted by the interested party. Staff may request additional information from the interested party, which must be received in writing by hand delivery, United States (U.S.) mail, or special mail delivery by the lead staff member no later than 14 calendar days from the date the interested party receives the written request for additional information. If the 14th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 14th calendar day is the final day the receipt of the additional information will be accepted. Information received after 14 calendar days may not be used in the informal review [~~panel's~~] written decision unless the interested party receives written approval of the lead staff member to submit the information after 14 calendar days. A request for an extension to the 14-calendar-day due date must be received by HHSC Rate Analysis prior to the 14th calendar day.

(B) Within 30 calendar days of the date a written request for informal review that complies with paragraphs (1) and (2) of this subsection is received or the date additional requested information is due or received, whichever is later, the lead staff member will send the interested party its written decision by certified mail, return receipt requested. If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day by which the written decision must be sent.

(d) Administrative hearings. An interested party who disagrees with the results of an informal review conducted under subsection (c) of this section may file a formal appeal of the review. The HHSC Appeals Division, Mail Code W-613, P.O. Box 149030, Austin, Texas 78714-9030, must receive the written request for a formal appeal from the interested party within 15 calendar days after the interested party receives the written decision as specified in subsection (c) of this section. The written request for a formal appeal must state the basis of the appeal of the adverse action and include a legible copy of the written decision from the informal review referenced in subsection (c)(2)(B) of this section. The formal appeal is limited to the issues that were considered in the informal review process. The information from the interested party is limited to the pertinent information considered in the informal review process. Formal appeals are conducted in accordance with the provisions of §§357.481 - 357.498 of this title. If there is a conflict between the applicable section of Chapter 357 of this title (relating to Hearings) and the provisions of this chapter, the provisions of this chapter prevail.

(e) Lack of standing for formal appeal. Because the formal appeal is limited to issues considered in the informal review process, an informal review request that does not comply with subsection [~~subsections~~] (c)(1)(A) - (C) of this section is not subject to further appeal under §§357.481 - 357.498 of this title.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 8, 2011.

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Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6586

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SUBCHAPTER F. REIMBURSEMENT METHODOLOGY FOR PROGRAMS SERVING PERSONS WITH MENTAL ILLNESS AND MENTAL RETARDATION

The Texas Health and Human Services Commission (HHSC) proposes to repeal §355.741, concerning Definitions for Service Coordination and Targeted Case Management, and §355.742, concerning Service Limitations for Mental Retardation Service Coordination and Targeted Case Management; and proposes to amend §355.743, concerning Reimbursement Methodology for Mental Health Case Management.

Background and Justification

HHSC proposes to repeal §355.741 and §355.742 because this information will be incorporated into the cost determination process rules and other agency program rules or policy.

Additionally, HHSC proposes to amend §355.743 to eliminate the current cost settlement process and implement a prospective uniform statewide reimbursement rate methodology.

The Centers for Medicare and Medicaid Services (CMS) informed HHSC that the current cost settlement process for Mental Health Case Management was not acceptable and that the cost settlement would need to be either changed or eliminated. This proposal eliminates the cost settlement methodology and replaces it with a prospective uniform statewide reimbursement rate, which CMS has indicated is acceptable.

This proposal will also clarify current requirements for the Mental Health Case Management program and delete outdated information.

Section-by-Section Summary

The proposed repeals of §355.741 and §355.742 will allow applicable information to be incorporated into the cost determination process rules or program guidelines and will delete outdated information.

Proposed §355.743(a) eliminates references to the Texas Department of Mental Health and Mental Retardation (TDMHMR), which no longer exists; establishes the Department of State Health Services (DSHS) as the agency responsible for determining program eligibility; and adds a reference identifying where the rate determination authority can be found.

Proposed §355.743(b) replaces the term "separate" with "reimbursement," adds language describing the types of reimbursement rates, and eliminates outdated information.

Proposed §355.743(c) adds language stating that the 15-minute unit of service is prospective and uniform statewide and removes information stated in agency program rules that is not pertinent to the reimbursement methodology.

Proposed §355.743(d)(1) and (d)(2) describe the reimbursement methodology for determining initial rates effective September 1, 2011, and for determining rates after September 1, 2011, and deletes obsolete language.

Proposed §355.743(e) describes the cost reporting process and references the cost determination process rules that govern cost reporting and adjustments to reported costs and removes the current rate determination methodology including removal of cost settlement provisions (also known as reconciliation) of the reimbursement methodology.

The proposed amendment to §355.743 also deletes subsections (f) - (h) to: (1) eliminate references to TDMHMR; (2) remove information stated in agency program rules or policy; (3) remove the description of the unit of service that will be described elsewhere; and (4) eliminate language regarding the reporting of costs that are contained in the cost determination process rules, which are referenced in the new subsection (e).

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that, during the first five-year period the amendment and repeals are in effect, there is no fiscal impact to the State or local governments. However, individual providers will have their payment rates increased or decreased as a result of this change.

Small and Micro-business Impact Analysis

Carolyn Pratt, Director of Rate Analysis, has determined that there will be no adverse economic effect on small or micro-businesses as a result of enforcing or administering the proposed section, because the providers of this service are Mental Health Authorities, which are governmental entities recognized by the State. There is no anticipated economic cost to persons who are required to comply with the proposed section. There is no anticipated effect on local employment in geographic areas affected by this section.

Public Benefit

Ms. Pratt has also determined that for each of the first five years the amendment and repeals are in effect, the expected public benefit is the elimination of duplicate and obsolete rules and that HHSC will provide consistency in the cost reporting rules with other HHSC programs that submit cost reports and will define the new reimbursement methodology for this service.

Regulatory Analysis

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

Takings Impact Assessment

HHSC has determined that this 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 §2007.043 of the Government Code.

Public Comment

Written comments on the proposal may be submitted to Yvonne Moorad, Senior Rate Analyst, Acute Care Services, Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax to (512) 491-1998; or by e-mail to Yvonne.Moorad@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register.*

1 TAC §355.741, §355.742

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Health and Human Services Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

Statutory Authority

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

and rates for medical assistance payments under the Human Resources Code, Chapter 32.

The repeals affect the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.741. Definitions for Service Coordination and Targeted Case Management.

§355.742. Service Limitations for MR Service Coordination and Targeted Case Management.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 424-6576

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1 TAC §355.743

Statutory Authority

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

The amendment affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.743. Reimbursement Methodology for Mental Health Case Management.

(a) Authority. Payments are made to qualified providers delivering [~~The Texas Department of Mental Health and Mental Retardation (TDMHMR) or its successor agency reimburses qualified community mental health centers for~~] Mental Health Case Management (CM) [~~provided~~] to Medicaid-enrolled [~~eligible~~] individuals who are eligible for CM according to program rules established by the Department of State Health Services (DSHS) [~~TDMHMR or its successor agency~~]. The reimbursement determination authority is specified in §355.101 of this title (relating to Introduction).

(b) Reimbursement [~~Separate~~] rates. Separate rates are set for services based on the following [~~their intensity~~]:

(1) Site-based setting. Routine CM is a face-to-face contact with the client at the provider's place of business (e.g., clinic, outpatient office). [~~which is a low intensity service that will be provided to both adults and children who need limited assistance in obtaining access to services and is primarily site-based; and~~]

(2) Community-based setting. Intensive CM is a face-to-face contact with the client at the client's home, work place, school, or other location that best meets the need of the client. [~~high-intensity service that will be provided to just children who need a greater level of assistance in obtaining services and is primarily community-based.~~]

(c) Qualified providers are reimbursed based on a 15-minute face-to-face unit of service that is prospective and uniform statewide.

(d) Rate methodology.

(1) Initial rates. The initial rates effective September 1, 2011, will be determined by summing the total agency expenditures for each type of case management service for the most recent cost-settled fiscal year, and dividing by the total number of units of each type of service provided during that fiscal year. The total agency expenditures to provide case management services include both the interim rates paid and any adjustments made to the interim rates, such as additional payments or recoupments.

(2) Cost report-based rates. After the Health and Human Services Commission (HHSC) determines that cost data collected as described in subsection (e) of this section is reliable and sufficient to support development of a cost report-based rate, HHSC will develop statewide reimbursement rates using the data that replaced the initial rates as follows:

(A) Project each provider's total allowable cost per type of service from the historical cost reporting period to the prospective reimbursement period using inflation factors according to §355.108 of this title (relating to Determination of Inflation Indices);

(B) For each provider, divide the projected cost per type of service, determined in subparagraph (A) of this paragraph, by the provider's total units of service per type of service delivered during the historical cost reporting period, to arrive at the provider's projected cost per unit of service for each type of service; and

(C) For each type of service:

(i) Arrange all providers' projected cost per unit of service in an array from low to high, with the corresponding total number of units of service for each provider;

(ii) Sum the total number of units of service for each provider in the array progressively, from the lowest projected cost per unit to the highest, to create a running total;

(iii) Divide the total number of units of service by two;

(iv) Identify the value, from the running total sums calculated in clause (ii) of this subparagraph, that is closest to the result in clause (iii) of this subparagraph; and

(v) Identify the cost per unit of service that corresponds to the value identified in clause (iv) of this subparagraph, to arrive at the recommended rate for that service.

(e) Reporting of costs. CM providers must submit cost report data according to HHSC's specifications.

(1) All CM providers must submit a cost report unless the number of days between the date the first client received services and the fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost-report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the HHSC Rate Analysis Department before the due date of the cost report.

(2) CM service providers must submit cost report data according to HHSC's specifications. In addition to the requirements of

this section, the following cost reporting guidelines apply: §355.101 of this title (relating to Introduction); §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs); §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs); §355.104 of this title (relating to Revenues); §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures); §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports); §355.107 of this title (relating to Notification of Exclusions and Adjustments); §355.108 of this title (relating to Determination of Inflation Indices); §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs); §355.110 of this title (relating to Informal Reviews and Formal Appeals); and §355.111 of this title (relating to Administrative Contract Violation).

(3) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended rates. To ensure that the database reflects costs and other information that are necessary for the provision of services and is consistent with federal and state regulations, HHSC excludes from rate determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers.

(4) Individual provider cost reports may not be included in the database used for reimbursement determination if:

(A) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(B) an auditor determines that reported costs are not verifiable.

~~[(c) Section 1396n(g) of Title 42 of the U.S. Code is invoked to limit the provision of CM to state mental health authorities, TDMHMR or its successor agency, or its designated community mental health centers authorized under §534.054 of the Texas Health and Safety Code, who offer a service delivery system of required services as outlined in §534.053 of the Texas Health and Safety Code.]~~

~~[(d) Rules and procedures. TDMHMR or its successor agency has implemented rules and procedures to ensure that CM is provided by persons who meet the requirements specified by TDMHMR or its successor agency and is provided in compliance with federal and state laws, rules, and regulations.]~~

~~[(e) Reimbursement methodology. HHSC determines reimbursement according to §355.101 of this title (relating to Introduction). HHSC may also adjust reimbursement if new legislation, regulations or economic factors affect costs, according to §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).]~~

~~[(1) At the end of each reimbursement period HHSC will compare the difference between the interim rate and each community mental health center CM costs as submitted on its cost report in accordance with subsection (g) of this section.]~~

~~[(A) If a community mental health center's costs are less than 95 percent of the interim rate, the community mental health center will pay TDMHMR the difference between that community mental health center's costs and 95 percent of the interim rate. The community mental health center will be notified of the amount due to TDMHMR by certified mail.]~~

~~*[(i)* The community mental health center will have 30 days to make payment. If payment is not received from the community mental health center within 30 days of the date that the notice was received, as specified on the certified mail receipt, HHSC will notify TDMHMR to place the community mental health center on vendor hold.]~~

~~*[(ii)* A community mental health center that has been placed on vendor hold may request an administrative hearing in accordance with §355.110 of this title (relating to Informal Reviews and Formal Appeals).]~~

~~[(B) If a community mental health center's costs exceed the interim rate, TDMHMR will reimburse the community mental health center its costs up to 125 percent of the interim rate. TDMHMR will notify the community mental health center by certified mail of the amount that is owed to the community mental health center and will make payment within 30 days of the date that the notice was received, as specified on the certified mail receipt.]~~

~~[(2) At such time as HHSC determines that cost data collected as described in subsection (g) of this section are reliable, community mental health centers will be reimbursed a uniform statewide, interim rate with a cost-related year-end settle-up. The interim rate is determined biennially for each service type based on cost reports. Interim reimbursement rates will be developed based on the cost data submitted by community mental health centers in the following manner:]~~

~~[(A) Total allowable costs for each provider for each rate will be determined from analyzing the allowable historical costs reported on the cost report.]~~

~~[(B) Each provider's total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period using inflation factors according to §355.108 of this title (relating to Determination of Inflation Indices) for each covered contact.]~~

~~[(C) Each provider's projected cost per unit of service is calculated. The mean provider cost per contact is calculated, and the statistical outliers (those providers whose cost per contact exceeds plus or minus (+/-) two standard deviations of the mean provider cost per contact) are removed. After removal of the statistical outliers, the mean cost per contact is calculated. This mean cost per contact becomes the recommended cost per contact. Following each annual reimbursement period, allowable costs will be compared to reimbursement and any resulting monetary reconciliation will be made in accordance with paragraph (2) of this subsection.]~~

~~[(f) Reimbursable unit of service.]~~

~~[(1) The unit of service upon which reimbursement is made is a face-to-face contact with a Medicaid-eligible individual eligible for CM in accordance with TDMHMR's or its successor agency's program rules by:]~~

~~[(A) a community mental health center as required by subsection (c) of this section; and]~~

~~[(B) a person who meets the qualifications set forth in TDMHMR's or its successor agency's program rules.]~~

~~[(2) The face-to-face contact must include the provision of one or more services as defined in TDMHMR's or its successor agency's program rules.]~~

~~[(3) Reimbursement is one unit of service per 15 continuous minutes of face-to-face contact with a Medicaid-eligible individual.]~~

[(g) Reporting of costs. HHSC or its designee collects from community mental health centers statistical and cost data. The statistical data includes, but is not limited to, the total number of individuals receiving CM, and the number of Medicaid-eligible individuals receiving CM. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs.]

[(1) Cost reports. Each community mental health center must submit financial and statistical information in a cost report or survey format designated by HHSC or its designee. The cost report will capture the expenses of the community mental health center including salaries and benefits, administration, building and equipment, utilities, supplies, travel, and indirect overhead costs related to the provision of CM Only allowable cost information is used to compile the cost base. Each community mental health center must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §355.102 & §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs). Community mental health centers must follow the cost-reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).]

[(A) Accounting requirements. All information submitted on the cost reports must be based upon the accrual method of accounting unless the governmental entity operates on a cash or modified accrual basis. The community mental health center must complete the cost report according to the prescribed statement of allowable and unallowable costs as referenced in §355.101 of this title (relating to Introduction). Cost reporting should be consistent with generally accepted accounting principles (GAAP). In cases in which cost reporting rules conflict with GAAP, Internal Revenue Service, or other authorities, the cost reporting rules take precedence.]

[(B) Reporting period. The community mental health center must prepare the cost report according to §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).]

[(2) Exclusions or adjustments. Community mental health centers must exclude unallowable costs from the cost report. HHSC or its designee excludes from the cost reimbursement base any unallowable costs included in the cost report and makes adjustments to expenses reported by community mental health centers to ensure that the cost reimbursement base reflects costs which are consistent with efficiency, economy, and quality care, are necessary for the provision of CM services, and are consistent with federal and state Medicaid regulations as specified in §355.102 & §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs). If there is doubt as to the accuracy of allowability of a significant part of the information reported, individual cost reports may be eliminated from the cost base.]

[(3) Desk reviews. As specified in §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), HHSC or its designee reviews such cost reports or surveys. Cost reports not completed according to instructions or rules will be corrected and resubmitted by the community mental health center within the time frame prescribed by HHSC.]

[(4) On-site audit of cost reports. HHSC or its designee performs a sufficient number of audits each year to ensure the fiscal integrity of the CM reimbursement. The number of on-site audits actually performed each year may vary.]

[(A) HHSC or its designee notifies community mental health centers of disallowances and adjustments to reported expenses made during desk reviews and on-site audits of cost reports according to §355.107 of this title (relating to Notification of Exclusions and Adjustments).]

[(B) Reviews of cost report disallowances. A community mental health center that disagrees with HHSC or its designee on cost report disallowances, may request a review of the disallowances as specified in §355.110 of this title (relating to Informal Reviews and Formal Appeals).]

[(5) Recordkeeping requirements. Each community mental health center must maintain records according to the requirements specified in TDMHMR or its successor agency's rules and the provider agreement. The community mental health center must ensure that the records are accurate and sufficiently detailed to support the financial and statistical information reported in the cost report. If a community mental health center does not maintain records, which support the financial and statistical information submitted on the cost report, the community mental health center will be given 90 days to correct this recordkeeping. HHSC will notify TDMHMR or its successor agency to place the community center on vendor hold if the correction is not made within 90 days from the date the community mental health center receives notification.]

[(6) Access to records. The community mental health center must allow HHSC access to any and all records necessary to verify information on the cost report.]

[(h) Billing and payment reviews. The provider must allow TDMHMR or its successor agency access to any and all records regarding CM.]

[(1) TDMHMR or its successor agency will conduct periodic billing and payment reviews utilizing TDMHMR's or its successor agency's Billing and Payment Review Protocol.]

[(2) Recoupment will be taken according to the application of error calculations contained in TDMHMR's or its successor agency's Billing and Payment Review Protocol.]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Texas Health and Human Services Commission
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1 TAC §355.781

The Texas Health and Human Services Commission (HHSC) proposes to amend §355.781, concerning Rehabilitative Services Reimbursement Methodology.

Background and Justification

Providers in the mental health rehabilitation program are currently paid a statewide interim rate that is settled to each provider's costs within certain parameters. HHSC proposes to amend §355.781 to eliminate the current cost settlement

process and implement a prospective uniform statewide reimbursement rate methodology.

The Centers for Medicare and Medicaid Services (CMS) informed HHSC that the current cost settlement process for this program was not acceptable and that either the cost settlement would need to be changed or eliminated. This rule proposal eliminates the cost settlement methodology and replaces it with a prospective, uniform, statewide reimbursement rate that CMS has indicated is acceptable.

This proposal will also update and clarify current requirements for the Rehabilitative Services program and delete outdated information.

Section-by-Section Summary

Proposed amended §355.781(a) adds language that describes the type of service provided, establishes the Department of State Health Services (DSHS) as the agency responsible for determining program eligibility, and adds a reference that identifies where the rate determination authority can be found. Paragraphs (1) and (2) in subsection (a) are deleted to eliminate specific references to HHSC as the agency reimbursing a qualified rehabilitative service provider and to eliminate information regarding cost-effective operations and State appropriations that are not pertinent to the rate methodology.

Proposed amended §355.781(b) replaces the subsection title with a new title, adds language that specifies that rates are prospective and uniform statewide for defined services, and reformats the subsection. Additionally, the amendment deletes the definition of "interim rate" and "service type" and moves the definition of "unit of service" to subsection (c). The amendment also removes information set out in agency program rules that is not pertinent to the reimbursement methodology.

Proposed amended §355.781(c) describes the unit of service previously described in subsection (b)(3) and reformats the subsection. The amendment eliminates language regarding the reporting of costs that is contained in the cost-determination process rules that are referenced in the new subsection (e).

Proposed amended §355.781(d) eliminates language regarding the current reimbursement methodology and cost settlement provisions. Subsection (d)(1) describes the reimbursement methodology for determining initial rates effective September 1, 2011, and subsection (d)(2) describes the reimbursement methodology for determining rates effective after September 1, 2011.

Proposed new §355.781(e) describes the cost-reporting process and references the cost determination process rules, which govern cost reporting and adjustments to reported costs.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that during the first five-year period the amended rule is in effect there is no fiscal impact to the State. However, individual providers will have their payment rates increased or decreased as a result of this change. The current providers of this service are local mental health authorities, governmental entities recognized by the State.

Small and Micro-business Impact Analysis

Carolyn Pratt, Director of Rate Analysis, has determined that there will be no adverse economic effect on small or micro-businesses as a result of enforcing or administering the proposed section, because the proposal does not require them to alter their current business or administrative practices as a result of the amendment. There is no anticipated economic cost to persons who are required to comply with the proposed section. There is no anticipated effect on local employment in geographic areas affected by this section.

Public Benefit

Carolyn Pratt has also determined that for each of the first five years the amendment is in effect, the expected public benefit of the amendment is the elimination of duplicate and obsolete rules. The public benefit of the amendment is that HHSC will be consistent in its cost reporting rules and will define the new reimbursement methodology for this service.

Regulatory Analysis

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

Takings Impact Assessment

HHSC has determined that this 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 §2007.043 of the Government Code.

Public Comment

Written comments on the proposal may be submitted to Yvonne Moorad, Senior Rate Analyst, Acute Care Services, Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax to (512) 491-1998; or by e-mail to Yvonne.Moorad@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register.*

Statutory Authority

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

The amendment affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.781. Rehabilitative Services Reimbursement Methodology.

(a) Authority. Payments are made to qualified providers delivering rehabilitative services to Medicaid-eligible individuals who are eligible for rehabilitative services according to the program rules established by the Department of State Health Services (DSHS). The re-

imbursement determination authority is specified in §355.101 of this title (relating to Introduction). [~~General information.~~]

[~~(1) The Texas Health and Human Services Commission (HHSC) will reimburse qualified rehabilitative services providers for rehabilitative services provided to Medicaid-eligible persons with mental illness.~~]

[~~(2) The HHSC establishes the reimbursement rate. The HHSC sets reimbursement rates that reflect cost-effective operations and are within State appropriation constraints.~~]

(b) Reimbursement rates. Prospective and uniform statewide rates for rehabilitative services are determined for rehabilitative services specified in the Mental Health Services program rules in 25 TAC Chapter 419, Subchapter L (relating to Mental Health Rehabilitative Services) for the following: [~~Definitions.~~]

[~~(1) Interim rate--Rate paid to a rehabilitative services provider based on cost reports prior to settle-up conducted in accordance with subsection (d)(4) of this section.~~]

[~~(2) Service type--Types of Medicaid reimbursable rehabilitative services as specified in program rules for the following:~~]

(1) [~~(A)~~] Day programs for acute needs--adult;

(2) [~~(B)~~] Crisis intervention services--individual-child/adolescent and adult;

(3) [~~(C)~~] Medication training and support--individual-child/adolescent and adult;

(4) [~~(D)~~] Medication training and support--group-adult;

(5) [~~(E)~~] Medication training and support--group-child/adolescent;

(6) [~~(F)~~] Psychosocial rehabilitative services--individual-adult;

(7) [~~(G)~~] Psychosocial rehabilitative services--group-adult;

(8) [~~(H)~~] Skills training and development--individual-child/adolescent and adult;

(9) [~~(I)~~] Skills training and development--group-adult; and

(10) [~~(J)~~] Skills training and development-group-child/adolescent.

(c) Units of service. Qualified providers are reimbursed based on the following face-to-face units of service:

[~~(3) Unit of service--The amount of time an individual, eligible for Medicaid rehabilitative services or non-Medicaid rehabilitative services (or parent or guardian of the person of an eligible minor), is engaged in face-to-face contact with a person described in program rules established by The Department of State Health Services (DSHS. The units of service are as follows:~~]

(1) [~~(A)~~] Day programs for acute needs--45-60 continuous minutes;

(2) [~~(B)~~] Crisis intervention services--15 continuous minutes;

(3) [~~(C)~~] Medication training and support--15 continuous minutes;

(4) [~~(D)~~] Psychosocial rehabilitative services--15 continuous minutes; and

(5) [~~(E)~~] Skills training and development--15 continuous minutes.

(d) Rate methodology.

(1) Initial rates. Initial statewide rates effective September 1, 2011, will be determined by summing the total agency expenditures to provide rehabilitative services for each type of service for the most recent cost-settled fiscal year, and dividing by the total number of units of each type of service provided during that fiscal year. The total agency expenditure to provide rehabilitative services includes both the interim rates paid and any adjustments made to the interim rates, such as additional payments or recoupments.

(2) Cost report-based rates. After the Texas Health and Human Services Commission (HHSC) determines that cost data collected as described in subsection (e) of this section are reliable and sufficient to support development of a cost report-based rate, HHSC will develop statewide reimbursement rates using that data to replace the initial rates as follows:

(A) Project each provider's total allowable cost for each type of service from the historical cost reporting period to the prospective reimbursement period using inflation factors set out in §355.108 of this title (relating to Determination of Inflation Indices) to arrive at the projected cost for each type of service.

(B) For each provider, divide the projected cost for each type of service, determined in subparagraph (A) of this paragraph, by the provider's total units of service for each type of service delivered during the historical cost-reporting period, to arrive at the provider's projected cost for each unit of service for each type of service.

(C) For each type of service:

(i) Arrange all providers' projected cost for each unit of service in an array from low to high, with the corresponding total number of units of service for each provider;

(ii) Sum the total number of units of service for each provider in the array progressively from low to high to create a running total;

(iii) Divide the total number of units of service by two;

(iv) Identify the value, from the running total sums calculated in clause (ii) of this subparagraph, that is closest to the result in clause (iii) of this subparagraph; and

(v) Identify the cost for each unit of service that corresponds to the value identified in clause (iv) of this subparagraph to arrive at the recommended rate for that service.

(e) Reporting of costs.

(1) All rehabilitative services providers must submit a cost report unless the number of days between the date the first client received services and the fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost-report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the HHSC Rate Analysis Department before the due date of the cost report.

(2) Cost reporting. Rehabilitative services providers must submit cost report data according to HHSC's specifications. In addition to the requirements of this section, the cost reporting guidelines will be governed by the information in §355.101 of this title (relating to Introduction), §355.102 of this title (relating to General Principles

of Allowable and Unallowable Costs), §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this title (relating to Revenues), §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures), §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), §355.107 of this title (relating to Notification of Exclusions and Adjustments), §355.108 of this title (relating to Determination of Inflation Indices), §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs), §355.110 of this title (relating to Informal Reviews and Formal Appeals), and §355.11 of this title (relating to Administrative Contract Violation).

(3) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended rates. To ensure that the database reflects costs and other information that are necessary for the provision of services and is consistent with federal and state regulations, HHSC excludes from rate determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers.

(4) Individual provider cost reports may not be included in the database used for reimbursement determination if:

(A) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(B) an auditor determines that reported costs are not verifiable.

~~[(c) Reporting of Costs.]~~

~~[(1) Cost reporting. Rehabilitative services providers must submit information quarterly, unless otherwise specified, on a cost report formatted according to HHSC's specifications. Rehabilitative services providers must complete the cost report according to §§355.101, 355.102, 355.103, 355.104, and 355.105 of this title (relating to Introduction, General Principles of Allowable and Unallowable Costs, Specifications for Allowable and Unallowable Costs, Revenues, and General Reporting and Documentation Requirements, Methods, and Procedures).]~~

~~[(2) Reporting period and due date. Rehabilitative services providers must prepare the cost report to reflect rehabilitative services provided during the designated cost report-reporting period. The cost reports must be submitted to the HHSC no later than 45 days following the end of the designated reporting period unless otherwise specified by the HHSC.]~~

~~[(3) Extension of the due date. The HHSC may grant extensions of due dates for good cause. A good cause is one that the rehabilitative services provider could not reasonable be expected to control. Rehabilitative services providers must submit request for extensions in writing. Requests for extensions must be received by HHSC prior to the cost report due date. HHSC will respond to requests within 15 days of receipt.]~~

~~[(4) Failure to file an acceptable cost report. If a rehabilitative services provider fails to file a cost report according to all applicable rules and instructions, HHSC will notify DSHS to place the rehabilitative services provider on vendor hold until the rehabilitative services provider submits an acceptable cost report.]~~

~~[(5) Allocation method. If allocations of cost are necessary, rehabilitative services providers must use and be able to document reasonable methods of allocation. HHSC adjusts allocated costs if HHSC considers the allocation method to be unreasonable. The rehabilitative services provider must retain work papers supporting allocations for a period of three years or until all audit exceptions are resolved (whichever is longer).]~~

~~[(6) Cost report certification. Rehabilitative services providers must certify the accuracy of cost reports submitted to HHSC in the format specified by HHSC. Rehabilitative services providers may be liable for civil and/or criminal penalties if they misrepresent or falsify information.]~~

~~[(7) Cost data supplements. HHSC may require additional financial and statistical information other than the information contained on the cost report.]~~

~~[(8) Allowable and unallowable costs. Cost reports may only include costs that meet the requirements as specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs).]~~

~~[(9) Review of cost reports. HHSC reviews each cost report to ensure that financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk review. HHSC reviews all cost reports according to the criteria specified in §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). If a rehabilitative services provider fails to complete the cost report according to instructions or rules, HHSC returns the cost report to the rehabilitative services provider for proper completion. HHSC may require information other than that contained in the cost report to substantiate reported information. Providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this title (relating to Notification of Exclusions and Adjustments).]~~

~~[(10) On-site audits. HHSC may perform on-site audits on all rehabilitative services providers that participate in the Medicaid program for rehabilitative services. HHSC determines the frequency and nature of such audits but ensures that they are not less than that required by federal regulations related to the administration of the program.]~~

~~[(11) Notification of exclusions and adjustments. HHSC notifies rehabilitative services providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of cost reports.]~~

~~[(12) Reviews and administrative hearings. Rehabilitative services providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by HHSC1 under §355.110 of this title (relating to Informal Reviews and Formal Appeals).]~~

~~[(13) Access to records. Each rehabilitative services provider must allow access to all records necessary to verify cost report information submitted to HHSC. Such records include those pertaining to related-party transactions and other business activities engaged in by the rehabilitative services provider. If a rehabilitative services provider does not allow inspection of pertinent records within 14 days following written notice HHSC will notify DSHS to place the rehabilitative services provider on vendor hold until access to the records is allowed. If the rehabilitative services provider continues to deny access to records, DSHS may terminate the rehabilitative services provider agreement with the rehabilitative services provider.]~~

~~[(14) Record keeping requirements. Rehabilitative services providers must maintain service delivery records and eligibility determination for a period of five years or until any audit exceptions are resolved (whichever is later). Rehabilitative services providers~~

must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports.]

[(15) Failure to maintain adequate records. If a rehabilitative services provider fails to maintain adequate records to support the financial and statistical information reported in cost reports, HHSC allows 30 days for the rehabilitative services provider to bring record keeping into compliance. If a rehabilitative services provider fails to correct deficiencies within 30 days from the date of notification of the deficiency, HHSC will notify DSHS to terminate the rehabilitative services provider agreement with the rehabilitative services provider.]

[(d) Reimbursement determination. HHSC determines reimbursement according to §355.101 of this title (relating to Introduction). Rehabilitative services providers are reimbursed a uniform, statewide interim rate with a cost-related year-end settle-up. The HHSC determines reimbursement in the following manner:]

[(1) Inclusions of certain reported expenses. Rehabilitative services providers must ensure that all allowable costs are included in the cost report.]

[(2) Data collection. The HHSC collects several different kinds of data. These include the number of units of service that individuals receive and cost data, including direct costs, programmatic indirect costs, and general and administrative overhead costs. These costs include salaries, benefits, and other costs. Other costs include non-salary related costs such as building and equipment maintenance, repair, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; and material and supply expenses.]

[(3) Interim rate methodology. The interim rate is determined biennially for each service type based on cost reports.]

[(A) The HHSC projects and adjusts reported costs from the historical reporting period to determine the interim rate for the prospective reimbursement period. Cost projections adjust the allowed historical costs based on significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective reimbursement period. Changes in cost-related conditions include, but are not limited to, inflation or deflation in wage or price, changes in program utilization and occupancy, modification of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements. Costs are adjusted for the prospective reimbursement period by a general cost inflation index as specified in §355.108 of this title (relating to Determination of Inflation Indices).]

[(B) For each settle-up service, each rehabilitative services provider's projected cost per unit of service is calculated. The mean rehabilitative services provider cost per unit of service is calculated, and the statistical outliers (those rehabilitative services providers whose unit costs exceed plus or minus (+/-) two standard deviations of the mean rehabilitative services provider cost) are removed. After removal of the statistical outliers, the mean cost per unit of service is calculated. This mean cost per unit of service becomes the recommended reimbursement per unit of service.]

[(4) Settle-up process. At the end of each reimbursement period, the HHSC will compare the amount reimbursed at the interim rate for each settle-up service and the rehabilitative services provider's costs for each service, as submitted on its cost report in accordance with subsection (c) of this section.]

[(A) Rehabilitative service provider's, whose costs are less than 95% of the amount reimbursed at the interim rate, will be required to pay to DSHS agency 100% of the difference between its allowable costs and 95% of the amount reimbursed at the interim rate for each settle-up service. DSHS will notify the rehabilitative services provider of the amount due by certified mail and the rehabilitative services provider will remit the repayment amount within 60 days of notification. DSHS will apply a vendor hold on Medicaid payments to a rehabilitative services provider for not making the payment to DSHS within 60 days of receiving notice.]

[(B) If a rehabilitative services provider's costs exceed the amount reimbursed at the interim rate, DSHS will reimburse the rehabilitative services provider the difference between its allowable costs and the reimbursement at the interim rate up to 125% of the interim rate for each settle-up service. DSHS will notify the rehabilitative services provider of the amount owed to the provider via certified mail. DSHS will make payment within 30 days of the date the notice was received, as indicated by the certified mail receipt.]

[(5) Adjustments to the reimbursement determination methodology. HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs as described in §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 11, 2011.

TRD-201101366
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 424-6576

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CHAPTER 371. MEDICAID AND OTHER HEALTH AND HUMAN SERVICES FRAUD AND ABUSE PROGRAM INTEGRITY

SUBCHAPTER G. LEGAL ACTION RELATING TO PROVIDERS OF MEDICAL ASSISTANCE

DIVISION 4. ADMINISTRATIVE SANCTIONS

1 TAC §371.1685

The Texas Health and Human Services Commission (HHSC) proposes an amendment to §371.1685, concerning use of criminal history record information, in Chapter 371, Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity.

Background and Justification

Human Resources Code §32.0322, relating to criminal history record information, provides the authority for HHSC or its Inspector General to perform criminal history checks on providers or persons applying to enroll as providers (applicants) in the Texas Medicaid program. If such a criminal history check reveals that an applicant or provider has been convicted of an offense listed in the rule, the applicant or provider is not eligible to participate in the Medicaid program. Section 371.1685 identifies specific offenses or types of offenses and provides that a conviction of aggravated assault or sexual assault (excludable offenses) renders an applicant or provider ineligible to participate in the Medicaid program. Conviction of aggravated sexual assault, however, is not included in the list of excludable offenses. HHSC is propos-

ing a conforming change to add a conviction for aggravated sexual assault to the list of excludable offenses.

Section-by-Section Summary

The proposed amendment to §371.1685 consists of only one substantive modification: the addition of new subsection (a)(5), which makes conviction of an offense under §22.021, Texas Penal Code, aggravated sexual assault, a conviction that renders an applicant or provider ineligible to participate in the Texas Medicaid program.

Minor modifications also are proposed, including renumbering former paragraphs (5) - (21) in subsection (a) to maintain a proper numerical sequence and clarifying cross-references within the section.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that, for the first five years the proposed amendment is in effect, enforcing or administering the amendment does not have foreseeable implications relating to costs or revenues of state or local governments.

Cost to Persons and Effect on Local Economies

Ms. Rymal does not anticipate that there will be any economic cost to persons who are required to comply with this proposal. The proposal will not affect a local economy. There is no anticipated negative impact on local employment.

Small Business and Micro-business Impact Analysis

Ms. Rymal has determined that there is no anticipated adverse economic effect on small businesses or micro-businesses, or on businesses of any size, as a result of administering the proposal. The rules do not impose any new requirements on providers or change any substantive Medicaid policies.

Public Benefit

Doug Wilson, HHSC Inspector General, has determined that, for each year of the first five years the amendment is in effect, the anticipated public benefit expected as a result of enforcing the amendment is that Medicaid recipients will be protected if persons convicted of violent offenses are excluded from participating as providers.

Regulatory Analysis

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

Takings Impact Assessment

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

Public Comment

Written comments on the proposal may be submitted to Lisa Barragan, Texas Health and Human Services Commission, P.O. Box 85200, MC H-400, Austin, Texas 78708-5200; by fax to (512) 833-6484; or by e-mail to lisa.barragan@hhsc.state.tx.us within 30 days of publication in the *Texas Register.*

Legal Authority

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient operation of the Medicaid program; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The amendment affects the Texas Government Code, Chapter 531, and the Human Resources Code, Chapter 32. No other statutes, articles or codes are affected by the proposal.

§371.1685. Use of Criminal History Record Information.

(a) If the Commission or Inspector General determines, based on [~~through~~] a criminal history check taken from the application for provider or performing provider status, that the provider or applicant has been convicted of one of the following crimes, the provider or applicant will not be eligible to participate in the Medicaid program, and, if enrolled, the Commission or Inspector General will terminate the provider's contract, or deny the application.

(1) An offense under chapter 19, Texas Penal Code (criminal homicide);

(2) An offense under chapter 20, Texas Penal Code (kidnapping and false imprisonment);

(3) An offense under section 21.11, Texas Penal Code (indecency with a child);

(4) An offense under section 22.011, Texas Penal Code (sexual assault);

(5) An offense under section 22.021, Texas Penal Code (aggravated sexual assault);

(6) [~~(5)~~] An offense under section 22.02, Texas Penal Code (aggravated assault);

(7) [~~(6)~~] An offense under section 22.04, Texas Penal Code (injury to a child, elderly individual, or disabled individual);

(8) [~~(7)~~] An offense under section 22.041, Texas Penal Code (abandoning or endangering a child);

(9) [~~(8)~~] An offense under section 22.08, Texas Penal Code (aiding suicide);

(10) [~~(9)~~] An offense under section 25.031, Texas Penal Code (agreement to abduct from custody);

(11) [~~(10)~~] An offense under section 25.08, Texas Penal Code (sale or purchase of a child);

(12) [~~(11)~~] An offense under section 28.02, Texas Penal Code (arson);

(13) [~~(12)~~] An offense under section 29.02, Texas Penal Code (robbery);

(14) [~~(13)~~] An offense under section 29.03, Texas Penal Code (aggravated robbery);

(15) [~~(14)~~] An offense under chapter 31, Texas Penal Code (theft);

(16) [~~(15)~~] An offense under chapter 32, Texas Penal Code (fraud);

(17) [~~(16)~~] An offense under chapter 34, Texas Penal Code (money laundering);

(18) [~~(17)~~] An offense under chapter 35, Texas Penal Code (insurance fraud);

(19) [~~(18)~~] An offense under chapter 36, Texas Penal Code (bribery and corrupt influence);

(20) [~~(19)~~] An offense under chapter 37, Texas Penal Code (perjury and other falsifications);

(21) [~~(20)~~] An offense under chapter 71.02, Texas Penal Code (engaging in organized criminal activity); or

(22) [~~(21)~~] A federal offense under the Racketeer Influenced and Corrupt Organizations Act, mail fraud, wire fraud, insurance fraud, Medicare Fraud, Medicaid Fraud, tampering with a government document, and/or violation of Federal False Claims Act.

(b) The prohibition also includes [~~shall also include~~] convictions for aiding and abetting any of the [~~above-listed~~] offenses listed in subsection (a) of this section or for conspiracies to commit any of the [~~above~~] offenses listed in subsection (a) of this section.

(c) The prohibition also includes [~~shall also include~~] any conviction under the laws of another state that prohibit [~~, which prohibits~~] the conduct described in the [~~above listed~~] offenses listed in subsection (a) of this section.

(d) Access to Criminal History Record Information.

(1) An agency operating part of the Medicaid program under Chapter 32, Human Resources Code, is entitled to obtain from the Commission or Inspector General the criminal history record information maintained by the Commission or Inspector General that relates to a provider under the Medicaid program or a person applying to enroll as a provider under the Medicaid program.

(2) Criminal history record information obtained by the Commission or Inspector General under §371.1683 of this division (relating to Criminal History Checks) [~~title~~], or obtained by an agency under [~~this~~] paragraph (1) of this subsection, may not be released or disclosed to any person except in a criminal proceeding, in an administrative proceeding, on court order, or with the consent of the provider or applicant.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 11, 2011.

TRD-201101363
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 424-6576

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TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 26. SUBSTANTIVE RULES APPLICABLE TO TELECOMMUNICATIONS SERVICE PROVIDERS

SUBCHAPTER J. COSTS, RATES AND TARIFFS

16 TAC §26.202

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Public Utility Commission of Texas or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Public Utility Commission of Texas (commission) proposes the repeal of §26.202, relating to Adjustment for House Bill 11, Acts of the 72nd Legislature, First Called Special Session 1991. This rule was enacted pursuant to Public Utility Regulatory Act (PURA) §53.202, relating to Adjustment for Change in Tax Liability, which the 72nd Legislature in 1991 adopted for the purpose of adjusting utilities' billings to reflect increases or decreases in their state franchise tax amounts owed pursuant to changes to the franchise tax law passed during that session. In 2007, House Bill 3 of the 80th Legislature replaced the state franchise tax with a new margins tax, thus rendering PURA §53.202 obsolete. In 2009, the 81st Legislature enacted Senate Bill 2565 to repeal PURA §53.202. As a result, the commission proposes the repeal of §26.202. Project Number 38040 is assigned to this proceeding.

Anjuli Winker, Financial Analyst, Rate Regulation Division, has determined that for each year of the first five-year period the repeal is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the repeal.

Mrs. Winker has determined that for each year of the first five years the rule is repealed the anticipated public benefit will be the updating of Chapter 26 of the commission's substantive rules to reflect the impact of legislative changes that occurred since the original adoption of the rule. There will be no adverse economic effect on small businesses or micro-businesses as a result of repealing the rule. Therefore, no regulatory flexibility analysis is required. There is no anticipated economic cost to persons who are required to comply with the repeal as proposed.

Mrs. Winker has also determined that for each year of the first five years the rule section is repealed there should be no effect on a local economy, and therefore no local employment impact statement is required under Administrative Procedure Act (APA), Texas Government Code §2001.022.

The commission staff will conduct a public hearing on this repeal, if requested pursuant to the Administrative Procedure Act, Texas Government Code §2001.029, at the commission's offices located in the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701. The request for a public hearing must be received on Monday, May 23, 2011.

Comments on the proposed repeal may be submitted to the Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326, on Monday, May 23, 2011. Reply comments may be submitted on

Monday, June 6, 2011. Sixteen copies of comments on the proposed repeal are required to be filed pursuant to §22.71(c) of this title. Comments should be organized in a manner consistent with the organization of §26.202. All comments should refer to Project Number 38040.

The repeal is proposed under PURA, Texas Utilities Code §14.002, which provides the commission the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction, and Senate Bill 2565, which repealed PURA §53.202.

Cross Reference to Statutes: Public Utility Regulatory Act §14.002 Acts 2007, 80th R.S., ch. 1351, General and Special Laws of Texas.

§26.202. Adjustment for House Bill 11, Acts of 72nd Legislature, First Called Special Session 1991.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 6, 2011.

TRD-201101343
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 936-7223

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 157. EMERGENCY MEDICAL CARE

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §157.41, concerning automated external defibrillators (AED) for public access defibrillation, and §157.49, concerning emergency medical services operator and operator instructor training and certification.

BACKGROUND AND PURPOSE

The amendments to §157.41 are necessary to clarify training and use guidelines, required by rule per Health and Safety Code, §779.002(b), for those who acquire an AED for non-professional use or by groups not licensed, certified or registered under Health and Safety Code, Chapter 773. It includes new language, per Health and Safety Code, §779.008, specifically stating it does not apply to AED use in hospitals licensed under Health and Safety Code, Chapter 241. This amendment clarifies physician involvement in training, adds after-use notification requirements, and defines lay responder, public access defibrillation and sudden cardiac arrest, which are not addressed in the current version of the rule. Under guidelines and procedures for use, this new language elaborates on procedural areas upon which a typical lay responder group should focus.

The amendments to §157.49 are necessary to update rule language to correct language referring to Texas Department of Health, Board of Health, and Bureau of Emergency Management which were changed during the department reorganization after the rule was readopted in 2004. Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 157.41 and 157.49 have been reviewed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

Amendments to §157.41 include a change to the rule title by adding "for public access defibrillation." The amendments define the terms lay responder, public access defibrillation and sudden cardiac arrest. Physician involvement in training and consultation is clarified. A requirement for users to notify the local EMS after use of an AED was added to comply with a statutory directive in Health and Safety Code, §779.004. Under the existing guidelines and procedures for use, additional language was added to describe fundamental aspects of nationally recognized standards as they relate to AED use procedures.

Section 157.49(b)(1) was amended by correcting the agency name to Texas Department of State Health Services; in subsection (b)(2), the Texas Board of Health (board) was replaced with department; subsection (e) was revised by replacing "bureau chief" with "department;" and subsection (o) was revised by replacing the names "the Texas Online Authority" and "Texas Online" with "texas.gov" to reflect the updated website for electronic transactions.

FISCAL NOTE

Renee Clack, Section Director, Health Care Quality Section, has determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to the state or local governments as a result of enforcing or administering §157.41 and §157.49 as proposed.

MICRO-BUSINESSES AND SMALL BUSINESSES IMPACT

Ms. Clack determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to small or micro-businesses as a result of enforcing or administering §157.41 and §157.49 as proposed. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

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

PUBLIC BENEFIT

Ms. Clack determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of these sections. The public benefit anticipated is clarity of lay responders' purpose and role in AED use, a better understanding of the physician's role and responsibilities and better clarity regarding the fundamentals for effective AED utilization, and to correct outdated references.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Comments on the proposal may be submitted to Jane Guerrero, Office of EMS/Trauma Systems Coordination, Health Care and Quality Section, Division of Regulatory Services, Department of State Health Services, Mail Code 1876, P.O. Box 149347, Austin, Texas 78714-9347, (512) 834-6700, or by email to Jane.Guerrero@dshs.state.tx.us. Comments will be accepted for 30 days following the publication of the proposal to the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

SUBCHAPTER C. EMERGENCY MEDICAL SERVICES TRAINING AND COURSE APPROVAL

25 TAC §157.41

STATUTORY AUTHORITY

The amendment is authorized by the Health and Safety Code, Chapters 773 and 779; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Chapter 1001, Health and Safety Code. Review of the rule implements Government Code, §2001.039.

The amendment affects Government Code, Chapter 531; and Health and Safety Code, Chapters 773, 779, and 1001.

§157.41. Automated External Defibrillators for Public Access Defibrillation.

(a) Purpose. The purpose of this rule is to establish minimum standards and requirements for training of lay responders [~~persons~~] using automated external defibrillators (AED).

(b) Excluded. [~~Exemption.~~] This section shall not apply to persons who are licensed, certified or registered under the Texas Health and Safety Code, Chapter 773, or to hospitals licensed under Health and Safety Code, Chapter 241.

(c) Definitions.

(1) Automated External Defibrillator (AED)--An electronic medical device approved by the United States Food and Drug Administration which is capable of recognizing the presence or absence of cardioventricular fibrillation or rapid cardioventricular tachycardia; is capable of determining, without interpretation of cardiac rhythm by an operator, whether defibrillation should be performed and, on determining that defibrillation should be performed, automatically charges and requests the operator to deliver an electrical impulse to an individual's heart.

(2) Cardiopulmonary Resuscitation (CPR)--A life saving procedure involving closed chest compressions and artificial respiration to an individual who is pulseless and apneic or who is experiencing agonal respiration.

(3) Lay Responder--A non-EMS-professional trained to respond to specific medical emergencies such as sudden cardiac arrest.

(4) Public Access Defibrillation--A comprehensive, integrated community approach to the use of AEDs by trained lay responders.

(5) Sudden Cardiac Arrest--A condition of sudden, unexpected loss of heart function, breathing and consciousness, usually resulting from an electrical disturbance in the heart that disrupts its pumping action and causes blood to stop flowing to the rest of the body.

(d) Training required.

(1) A person acquiring and/or using an AED shall successfully complete a training course in CPR and AED operation in accordance with the guidelines established by the device's manufacturer and as approved by the American Heart Association, the American Red Cross, other nationally recognized associations, or the medical director of the local emergency medical services provider.

(2) The person shall maintain that training in accordance with the guidelines established by the training association.

(3) A licensed physician shall be involved in the training program to ensure compliance with the requirements of this chapter. Physician involvement may be in the form of medical consultation or general oversight of the course.

(e) Notification required.

(1) A person or entity that acquires an AED shall immediately notify all local emergency medical service providers of the existence, physical location and type of device.

(2) A person or entity that uses an AED shall notify the local emergency medical service (911) provider after the AED is used.

(f) Guidelines and procedures for use. Use of an AED shall be in accordance with the guidelines established as nationally recognized standards and shall be in accordance with the manufacturer's operating procedures. The person or entity that acquires the AED should assure:

(1) AED prescription, purchase, use and maintenance records are retained;

(2) continuous involvement with the medical consultant and local EMS;

(3) appropriate placement of AED;

(4) maintenance of the AED;

(5) a core of trained users is maintained;

(6) liability exemption information is retained;

(7) the guidelines used are approved by the American Heart Association, the American Red Cross, other nationally recognized associations, or the medical director of the local emergency medical services provider;

(8) after-use procedures are developed and followed; and

(9) quality improvement procedures are developed and followed.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101352
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 458-7111 x6972

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SUBCHAPTER D. EMERGENCY MEDICAL SERVICES PERSONNEL CERTIFICATION

25 TAC §157.49

STATUTORY AUTHORITY

The amendment is authorized by the Health and Safety Code, Chapters 773 and 779; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Chapter 1001, Health and Safety Code. Review of the rule implements Government Code, §2001.039.

The amendment affects Government Code, Chapter 531; and Health and Safety Code, Chapters 773, 779, and 1001.

§157.49. Emergency Medical Services Operator and Operator Instructor Training and Certification.

(a) (No change.)

(b) Provision of medical information.

(1) An EMS information operator may provide medical information to a member of the public during an emergency call if the information operator has successfully completed an EMS information operator training program approved by the Texas Department of State Health Services (department) and holds a certificate issued under the provisions of this section or holds equivalent credentials recognized by the department; and

(2) An EMS information operator may provide medical information to a member of the public during an emergency call if the information provided conforms to the protocol and medical direction for delivery of the information adopted by the department [~~Texas Board of Health~~ (~~board~~)] under the provisions of subsection (c) of this section.

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

(e) Recognition by equivalent credentials. Upon written request to the department [~~bureau chief~~] and submission of its program's curriculum, the department may approve credentials issued by an emergency medical dispatch certification agency, organization, or by another state as being equivalent to EMS information operator certification.

(f) - (i) (No change.)

(j) EMS information operator instructor certification.

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

(4) Retesting.

(A) A certificant who does not pass the department's written examination may retest after:

(i) submitting an application to retest; [~~:~~] and

(ii) (No change.)

(B) (No change.)

(k) - (n) (No change.)

(o) For all applications and renewal applications, the department [(~~or the board~~)] is authorized to collect subscription and convenience fees, in amounts determined by texas.gov [~~the Texas Online Authority~~], to recover costs associated with application and renewal application processing through texas.gov [~~Texas Online~~].

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101359
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 458-7111 x6972

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CHAPTER 421. HEALTH CARE INFORMATION

SUBCHAPTER D. COLLECTION AND RELEASE OF OUTPATIENT SURGICAL AND RADIOLOGICAL PROCEDURES AT HOSPITALS AND AMBULATORY SURGICAL CENTERS

25 TAC §§421.61, 421.62, 421.66 - 421.68

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§421.61, 421.62, and 421.66 - 421.68 concerning the collection and release of data relating to individual patients who have had surgical procedures or radiological procedures performed in Texas hospitals (as an outpatient service including in the emergency department) or ambulatory surgical centers.

BACKGROUND AND PURPOSE

Sections 421.61 - 421.68 relate to the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers. The department began collecting data on outpatient services at hospitals and ambulatory

surgery centers in October 2009. The rules were originally developed and adopted by the Texas Health Care Information Council (council) and were transferred to the department on September 1, 2004, as a result of the consolidation of health and human services agencies under House Bill 2292 (HB 2292), 78th Texas Legislature, 2003, and then were amended to comply with Sections 2 and 3 of Senate Bill 1731 (SB 1731), 80th Texas Legislature, 2007, which amended the Health and Safety Code, Chapter 108.

Health and Safety Code, Chapter 108, requires the Executive Commissioner to adopt rules to implement the collection and release of data from health care facilities. The proposed amendments are necessary to clarify the scope of the data to be reported to the department regarding which outpatients receiving surgical or radiological services. Several facilities and contract vendors have contacted department staff regarding which patient data they are required to submit. Many of the questions involved the revenue codes that are listed in §421.67(f). For example "Do we send only those charges for the revenue codes listed in the rules?" or "Some of the payers do not require revenue codes, so we do not put them on the claim, do we need to send that data?" One data submitter asked why revenue code 0320 (Radiology--Diagnostic General Classification) was not included in the specified revenue code list in the rules, this code has been added to the list in §421.67(f). A stakeholder meeting was held on September 16, 2010 and two of the stakeholders recommended that the department retain the requirement of submitting outpatient data by revenue codes, since many hospitals select and extract their data according to the revenue codes. The stakeholders recommended that the department add the option to report by the Service and Procedure Categories as an alternative to the revenue code requirement.

Health and Safety Code, §108.009, requires providers to submit data as required by these sections. The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations at 45 Code of Federal Regulations, §164.512(a), allow health care providers to disclose protected health information without a patient's consent or authorization when disclosure is required by law. Since state law requires disclosure to the department, the HIPAA regulations allow the submission of the data.

The new data elements cannot be required to be submitted to the department before the 90th day after the date the rules are adopted and must take effect not later than the first anniversary after the date the rules are adopted.

Government Code, §2001.039, requires that each state agency review and consider for readopting each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 421.61 - 421.68 have been reviewed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed. However, §§421.63, 421.64, and 421.65 are not being changed at this time.

SECTION-BY-SECTION SUMMARY

The phrase "or surgical and radiological categories" is inserted after "revenue codes" and the reference is updated to include "or §421.67(g) in the following proposed sections: §421.61 - Definitions, paragraph (10) - Certification File and paragraph (38) - Outpatient or patient; §421.62(a) and (b); and §421.66(c)(3).

Section 421.61 is amended by adding definitions for "Radiological Procedures" and "Surgical Procedures" for the purposes of this subchapter. The terms are added to clarify which procedures performed on patients within the facility are required to have the required data elements submitted to the department.

Sections 421.61(b), 421.62(g), 421.66(g) and 421.68(j) contain the implementation date of July 1, 2009, which is no longer appropriate, and are being deleted.

Section 421.67(d) is amended by adding paragraph (33), "Service Line Date (effective 90 calendar days after being published in the *Texas Register)"* to the required minimum data set and renumbers the list of required data elements for facilities that provide one or more of the services that are included under the revenue codes specified in subsection (f) of this section for patients which are uninsured, considered as self pay, or are covered by a third-party payer which requires the facility to submit a claim in an ANSI 837 Institutional Guide format or CMS-1450 format. Subsection (f) is amended by adding revenue code "0320 Radiology--Diagnostic General Classification (effective 90 calendar days after being published in the *Texas Register)"* in paragraph (1), which was previously omitted inadvertently, and the other revenue codes are renumbered. Language is added to provide an option for identifying the required outpatient's data which should be submitted to the department. New subsection (g) establishes a listing of the Service and Procedure Categories and adds language which requires the department to publish on the department website a list of the Healthcare Common Procedural Code Set (HCPCS) codes relating to the categories by September 1 of the year before the data is to be submitted. The HCPCS codes are a list of procedure codes which cover many surgical and radiological procedures of outpatients that are high cost or high in volume whose data shall be submitted to the department in compliance with this subchapter. Subsection (g) is renumbered as subsection (h) of this section and contains a new implementation date of September 1, 2011.

Section 421.68(a) provides additional privacy and confidentiality protection for patients and physicians and states that event claims in any format submitted to the department are not available to the public and are exempt from disclosure and shall not be released.

FISCAL NOTE

Ramdas Menon, Ph.D., Director, Center for Health Statistics, has determined that for each calendar year of the first five years that the sections are in effect, there will be no fiscal implications to the state as a result of enforcing or administering the sections as proposed. The effect on state government will have no anticipated additional cost to the department, because of the addition of the Service Line Date data element in the §421.67(d) and the addition of revenue code "0320 Radiology--Diagnostic General Classification" and the addition of new subsection (g) which establishes the Services and Procedure category code list for facilities to identify which procedures they should submit to the department and requires the department to update the HCPCS codes yearly. The department's contractor will modify the system each year to filter out the patients based on the list of HCPCS codes from the list determined and published by department staff. The State Hospitals and Texas Center for Infectious Diseases indicated that they would not incur any additional costs to comply with the proposed amendments. The other state facilities provided no estimate of costs.

The fiscal implications of submitting the data with the additional service line date for the surgical procedures or radiological procedures covered by the specified revenue codes in §421.67(f) or the service and procedure categories listed in new subsec-

tion (g) of this section for local governments that own or operate hospitals or ambulatory surgical centers will vary. The costs are dependent on whether they already submit service line date on their data and on the complexity of the hospital's or ambulatory surgery center's information technology, or their contract requirements with any vendors involved in their information systems process. The facilities that submit all their outpatient data, would incur no additional costs. The department's contract vendors system would filter out the claims that do not have the appropriate revenue codes or the appropriate procedure codes, those records would not be entered into the system. Two of nine local government entities responded that they would incur no additional costs. The department estimates that costs for local government entities may range from no additional costs up to a similar one-time a year cost of $31.36 ($15.68 X approximately 2 hours) for first year costs with approximately $33, $34, $35, $37 and $38 per subsequent year on personnel costs, to identify which of the facilities procedures they perform are on the published procedure list.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS AND ECONOMIC IMPACT TO PERSONS

Dr. Menon anticipates that those hospitals or ambulatory surgical centers which are required to report under Health and Safety Code, Chapter 108, and these sections may or may not incur costs dependent upon the complexity of their information technology systems or their data submission process (some facilities submit all their outpatient data, therefore, would incur no additional costs). Hospitals and ambulatory surgical centers that create a separate data claim for the department that is different from their billing systems, or do not submit data electronically, will incur additional costs dependent on the complexity of their information technology system. Facilities that continue to sort out data by revenue codes may incur a small cost (dependent upon their system design) in updating their system to include the 0320 revenue code and the "service line date" data element if it is not already submitted. Facilities that choose to sort out the data by HCPCS codes will incur costs dependent on their ability to select the HCPCS code ranges published on the department website each year. Facilities that submit all outpatient data will incur no additional costs as a result of the proposed amendments. Rural hospitals are exempt from reporting; therefore, rural hospitals that might qualify as a small business or micro-business are not included in this analysis.

The department estimates that the number of hospitals and ambulatory surgical centers (ASC) that are small businesses (for-profit, independently owned, and under 100 employees or under $6 million in annual gross receipts) is approximately 110. The department is not aware of any hospitals (not including rural hospitals) that are micro-businesses (for-profit, independently owned, and under 20 employees). The department believes that the number of ambulatory surgical centers that are small businesses or micro-businesses is approximately 300, of which 200 are estimated to be micro-businesses.

Dr. Menon anticipates that hospitals and ambulatory surgical centers that are required to submit data will either submit all outpatient data or will modify their computer systems to sort, capture and submit the required data according to the rules and the proposed amendments. The hospitals and ambulatory surgical centers that are small businesses or micro-businesses that contract with a vendor or have built a computer system that is separate from their billing system may incur varying costs if they choose to modify their system to extract only the patients that have surgical or radiological procedures performed in their facilities. The costs depend upon the complexity of their systems and contract requirements with any vendors involved with the hospitals' or ambulatory surgical centers' information technology systems for sorting and submitting the data.

Cost estimates were requested and obtained for: (a) Licensed hospitals and ambulatory surgical centers were contacted; (b) Several ambulatory surgical centers, which are small businesses or micro-businesses. Based on this information, the department estimates that the economic impact of the sections on hospitals and ambulatory surgical centers that are small businesses or micro-businesses will range from no additional costs to an estimated one-time a year identification of the procedures performed in their facility that match to the procedure codes published by the department on their website $31.36 ($15.68 X approximately 2 hours) for first year costs, with approximately $33, $34, $35, $37 and $38 per subsequent year on personnel costs.

The department considered alternative methods of achieving the purposes of the proposed sections. The purposes of the sections could be broadly stated as enhancing the ability of the state and the department to collect data for analysis to assist the public in making informed choices when selecting a hospital or ambulatory surgical center for services. One alternative could be to not change the required revenue code list to surgical and radiological procedure categories and not require the collection of "Service Line Date," as proposed by these sections; in other words, not propose or adopt any new sections or amendments to these sections. Under that alternative, the department would continue to collect the inpatient hospital data and outpatient data that it currently collects. While this alternative would provide the public with the current data to help the public make choices, it would not provide clear instruction to the providers on which outpatients' data are required to be submitted to the department and the data reported by the department would not be accurately reported to the public, therefore the department would not be able to accurately enforce the rules for compliance. This alternative was not accepted.

Another alternative could be to collect all hospital outpatient data and ambulatory surgical center outpatient data. While this alternative would provide the public with the best set of data to help the public make choices and clear language to the providers regarding which patients' data to submit to the department, it is not fiscally feasible. This alternative, which is authorized by Health and Safety Code, Chapter 108, would require the department to collect and process over 30,000,000 outpatient records a year versus the estimated 3,200,000 outpatients that receive surgical or radiological procedures and would increase the contracted costs beyond the Texas Legislature appropriated funds for additional data collection, estimated to be sufficient for the outpatient data collection and analysis. This alternative was not accepted.

A third alternative could be to propose specific surgical and radiological procedure codes and collect data based on those codes, rather than revenue codes. In meetings and discussions with stakeholders representing hospitals and ambulatory surgical centers, the stakeholders requested the department to use revenue codes because of the relative stability of procedure codes and require fewer rule amendments and information system changes. Use of either type of codes would meet the purposes of these sections. The alternative of using procedures codes was not accepted because of the stated preference of the stakeholders.

The anticipated economic costs to persons (hospitals or ambulatory surgical centers that are required to report under Health and Safety Code, Chapter 108) who are required to comply with the sections as proposed will be dependent upon the complexity and status of their information systems and will range from no additional costs to an estimated $31.36 ($15.68 X approximately 2 hours) for the first year. The annual costs thereafter would range from zero to approximately $33, $34, $35, $37 and $38 per subsequent year on personnel costs.

There will be little effect on local employment. The department assumes that any person hired would be hired in the first year that the rules are in effect. No additional local employment is anticipated in the subsequent years.

PUBLIC BENEFIT

Dr. Menon has also determined that for each year of the first five years the sections are in effect, the public will benefit from the adoption of the amended sections. The public benefit anticipated as a result of collecting and reporting of this data is the ability to provide the public with data and information regarding the type of surgical services or radiological services, volume, average charges, and the complexity of patient services provided by the hospitals or ambulatory surgical centers. The public will benefit from health care provider reports and information about the quality of care being provided by hospital outpatient surgical services and ambulatory surgical centers. The standardized data and the reports and information developed by the department from the data will assist the consumer in making informed decisions on healthcare issues.

REGULATORY ANALYSIS

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Comments on the proposal may be submitted to Bruce M. Burns, D.C., Center for Health Statistics, Department of State Health Services, Mail Code 1898, P.O. Box 149347, Austin, Texas 78714-9347, Fax (512) 458-7740. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §§108.006, 108.009, 108.010, 108.011 and 108.013, which require the Executive Commissioner to adopt rules necessary to carry out Chapter 108 including rules on data collection requirements, to prescribe the process of data submission, to implement a methodology to collect and disseminate data reflecting provider quality, to specify data elements to be required for submission to the department and which data elements are to be released in a outpatient event public use data file; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

The amendments affect the Health and Safety Code, Chapters 108 and 1001; and Government Code, Chapter 531.

§421.61. Definitions.

[~~(a)~~] The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Accurate and Consistent Data--Data that has been edited by DSHS and subjected to provider validation and certification.

(2) Ambulatory Surgical Care Data--Data for events associated with facility services, which require surgery to be performed in an operating room on an anesthetized patient.

(3) Ambulatory surgical center--An establishment licensed as an ambulatory surgical center under the Health and Safety Code, Chapter 243.

(4) Anesthetized patient--For the purposes of this subchapter, an outpatient who receives an anesthetic (a substance that reduces sensitivity, feeling, or awareness to pain or bodily sensations or renders the patient unconscious) prior to surgical services from a hospital or ambulatory surgical center.

(5) ANSI 837 Institutional Guide--American National Standards Institute, Accredited Standards Committee X12N, 837 Health Care Institutional Claim Implementation Guide.

(6) ANSI 837 Professional Guide--American National Standards Institute, Accredited Standards Committee X12N, 837 Health Care Professional Claim Implementation Guide.

(7) APC--Ambulatory Payment Classification.

(8) APG--Ambulatory Patient Group (APG)--A prospective payment system (PPS) for hospital-based outpatient care developed by 3M™. APGs provide information regarding the kinds and amounts of resources utilized in an outpatient visit and classify patients with similar clinical characteristics.

(9) Audit--An electronic standardized process developed and implemented by DSHS to identify potential errors and mistakes in file structure format or data element content by reviewing data fields for the presence or absence of data and the accuracy and appropriateness of data.

(10) Certification File--One or more electronic files (may include reports concerning the data and its compilation process) compiled by DSHS that contain one record for each patient event which has at least one procedure covered in the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title (relating to Event Files--Records, Data Fields and Codes) submitted

for each facility under this subchapter during the reporting quarter and may contain one record for any patient event occurring during one prior reporting quarter for whom additional event claims have been received.

(11) Certification Process--The process by which a provider confirms the accuracy and completeness of the certification file required to produce the public use data file as specified in §421.66 of this title (relating to Certification of Compiled Event Data).

(12) Charge--The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules or write offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization.

(13) Clinical Classifications Software--A classification system that groups diagnoses and procedures into a limited number of clinically meaningful categories developed at the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ).

(14) CRG--Clinical Risk Grouping software which classifies individuals into mutually exclusive categories and, using claims data, assigns the patient to a severity level if they have a chronic health condition. Developed by 3M™ Corporation.

(15) Comments--The notes or explanations submitted by the facilities, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively.

(16) Data format--The sequence or location of data elements in an electronic record according to prescribed specifications.

(17) DSHS--Department of State Health Services, the successor state agency to the Texas Health Care Information Council and the Texas Department of Health.

(18) EDI--Electronic Data Interchange--A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions.

(19) Electronic Filing--The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine track magnetic tape, computer diskette or other magnetic media acceptable to DSHS.

(20) Emergency Department--Department or room within a hospital as determined by federal or state law for the provision of emergency health care.

(21) Emergency Department Data--Events associated with hospital services in an emergency department or emergency room.

(22) Error--Data submitted on a event file which are not consistent with the format and data standards contained in this subchapter or with auditing criteria established by DSHS.

(23) Ethnicity--The status of patients relative to Hispanic background. Facilities shall report this data element according to the following ethnic types: Hispanic or Non-Hispanic.

(24) Event--The medical screening examination, triage, observation, diagnosis or treatment of a patient within the authority of a facility.

(25) Event claim--A set of computer records as specified in §421.67 of this title relating to a specific patient. "Event claim" corresponds to the ANSI 837 Institutional Guide and ANSI 837 Professional Guide term, "Transaction set."

(26) Event file--A computer file as defined in §421.67 of this title periodically submitted on or on behalf of a facility in compliance with the provisions of this subchapter. "Event File" corresponds to the ANSI 837 Institutional Guide and ANSI 837 Professional Guide terms, "Communication Envelope" or "Interchange Envelope."

(27) Facility--For the purposes of this subchapter a facility is a hospital or ambulatory surgical center, required to report under the Health and Safety Code, Chapter 108 and this subchapter.

(28) Facility Type Indicators--An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that hospital (e.g., Hospital based ambulatory surgical unit and hospitals with an emergency department or emergency room) and ambulatory surgical centers. A facility may have more than one indicator.

(29) Geographic identifiers--A set of codes indicating the health service region and county in which the patient resides.

(30) HCPCS--Healthcare Common Procedure Coding System of the Centers for Medicare and Medicaid Services. This includes the "Current Procedural Terminology" (CPT) codes (maintained by the "American Medical Association" (AMA)), which are "Level 1" HCPCS codes.

(31) HIPPS--Health Insurance Prospective Payment System.

(32) Hospital--A public, for-profit, or nonprofit institution licensed as a general or special hospital (25 TAC §133.2(21)) of this title, or a hospital owned by the state.

(33) ICD--International Classification of Disease.

(34) IRB--Institutional Review Board composed of DSHS' appointees or agents who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the outpatient event public use data.

(35) Operating or Other Physician--The "physician" licensed by the Texas Medical Board or "other health professional" licensed by the State of Texas who performed the surgical or radiological procedure most closely related to the principal diagnosis.

(36) Other health professional--A person licensed to provide health care services other than a physician. An individual other than a physician who provides diagnostic or therapeutic procedures to patients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the facilities to examine, observe or treat patients.

(37) Other Provider--For the purposes of reporting on the modified ANSI 837 Institutional Guide, the physician, other health professional or facility as reported on a claim, who performed a secondary surgical or a primary or secondary radiological procedure on the patient for the event if they are not reported as the operating or other physician or the facility. In the case where a substitute provider (locum tenens) is used, that physician or other health professional shall be submitted as specified in this subchapter.

(38) Outpatient or patient--For the purposes of this subchapter a patient who receives surgical or radiological services from an ambulatory surgical center or a patient who receives surgical or ra-

diological services from a hospital and is not admitted to a hospital for inpatient services. Outpatients include patients who receive one or more services covered by the revenue codes or surgical and radiological categories that are specified in §421.67(f) or §421.67(g) of this title, which may occur in the emergency department, ambulatory care, radiological, imaging or other types of hospital units. Outpatient includes a patient who is transferred from an ambulatory surgical center to another facility or a hospital patient who is under observation and not admitted to the hospital.

(39) Patient account number--A number assigned to each patient by the facility, which appears on each computer record in a patient event claim. This number is not consistent for a given patient from one facility to the next, or from one admission to the next in the same facility. DSHS will delete or encrypt this number to protect patient confidentiality prior to release of data.

(40) Physician--An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151 et seq.

(41) Provider--For the purposes of this subchapter, a physician or facility.

(42) Public use data file--For the purposes of this subchapter, a data file composed of event claims which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of data imposed by statute.

(43) Race--A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Facilities shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other.

(44) Radiological procedures--For the purposes of this subchapter, diagnostic procedures performed on a patient using radiant energy devices (Projection Radiology (for example - X-ray), Computed Tomography, or other ionizing radiation) or diagnostic radioactive material or other non-ionizing imaging devices (e.g., Magnetic Resonance Imaging, Nuclear Medicine devices (for example Positron Emission Tomography), Sound Imaging devices (for example Ultrasound or Echocardiography), Thermal imaging devices, Diagnostic Light imaging devices (for example - diagnostic photography, endoscopy, and fundoscopy) and other diagnostic imaging devices.

(45) [~~(44)~~] Rendering provider or rendering other health professional--For the purposes of reporting on the modified ANSI 837 Professional Guide, the physician or other health professional who performed the surgical or radiological procedure on the patient for the event. In the case where a substitute provider (locum tenans) is used, that physician or other health professional shall be submitted as specified in this subchapter. For purposes of this definition, the term "provider" is not limited to only a physician, or facility as defined in paragraphs (27), (37) and (41) of this subsection.

(46) [~~(45)~~] Required minimum data set--The list of data elements for which facilities may submit an event claim for each patient event occurring in the facility. The required minimum data sets are specified in §421.67(d) and (e) of this title. This list does not include all the data elements that are required by the modified ANSI 837 Institutional Guide or modified ANSI 837 Professional Guide to submit an acceptable event file. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify or qualify subsequent data elements).

(47) [~~(46)~~] Research data file--A customized data file, which may include the data elements in the public use file and may include data elements other than the required minimum data set submitted to DSHS, except those data elements that could reasonably identify a patient or physician.

(48) [~~(47)~~] Submission--The transfer of a set of computer records as specified in §421.67 of this title that constitutes the event file for one or more reporting hospitals under this subchapter.

(49) [~~(48)~~] Submitter--The person or organization, which physically prepares an event file for one or more facilities and submits them under this subchapter. A submitter may be a facility or an agent designated by a facility or its owner.

(50) Surgical procedure--For the purposes of this subchapter, an invasive procedure that penetrates or breaks the skin or other patient tissue (in vivo) for the purpose diagnosing, evaluating, analyzing, monitoring or treating a patient.

(51) [~~(49)~~] THCIC Identification Number--A string of 6 characters assigned by DSHS to identify facilities for reporting and tracking purposes. For a facility operating multiple facility locations under one license number and duplicating services at those locations, the department will assign a distinguishable identifier for each separate facility location under one license number. The relationship of the identifier to the name and license number of the facility is public information.

(52) [~~(50)~~] Uniform patient identifier--A unique identifier assigned by DSHS to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across facilities and patient events. The relationship of the identifier to the patient-specific data elements used to assign it is confidential.

(53) [~~(51)~~] Uniform physician identifier--A unique identifier assigned by DSHS to a physician or other health professional who is reported as operating, rendering or other provider providing health care services or treating a patient in a facility and which remains constant across facilities. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(54) [~~(52)~~] Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

~~[(b) This section is effective 90 calendar days after being published in the *Texas Register.* The department will not implement or enforce this section until July 1, 2009, at the earliest.]~~

§421.62. Collection of Hospital Outpatient and Ambulatory Surgical Center Data.

(a) Each facility in operation for all or any of the reporting periods described in §421.63 of this title (relating to Schedule for Filing Event Files) shall submit to DSHS event claims as specified in §421.67 of this title (relating to Event Files--Records, Data Fields and Codes) on all patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title. All facilities that are exempt under the Health and Safety Code, §108.0025, but choose to participate in reporting under this subchapter, shall comply with the requirements in this subchapter. To the extent the medical screening examination, triage, observation, diagnosis or treatment is made by a health professional, other than a physician, data elements specified in §421.67(d)(25) - (30) or (e)(19) of this title shall be filled accordingly or data elements in §421.67(d)(26) or (29) in the modified ANSI 837 Institutional Guide or §421.67(e)(20) in the modified ANSI 837

Professional Guide shall be marked with one of DSHS approved temporary "Physician" or "Other health professional" code numbers and data elements in §421.67(d)(25)(A) - (C) or (28)(A) - (C) in the ANSI 837 Institutional Guide format or §421.67(e)(19)(A) - (C) in the ANSI 837 Professional Guide format may be left blank.

(b) All patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title shall be reported by the facility that prepares one or more bills for patient services. The facility shall submit an event claim corresponding to each bill containing the data elements required by §421.67 of this title. For all patients who received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title for which the facility does not prepare a bill for patient services, the facility shall submit an event claim containing the required minimum data set.

(c) - (f) (No change.)

[(g) This section is effective 90 calendar days after being published in the *Texas Register.* The department will not implement or enforce this section until July 1, 2009, at the earliest.]

§421.66. Certification of Compiled Event Data.

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

(c) The signed certification form shall represent that:

(1) - (2) (No change.)

(3) to the best of their knowledge and belief, the data submitted accurately represents the facility's administrative status of patients for which the services covered by the revenue codes or surgical and radiological categories identified in §421.67(f) or §421.67(g) of this title (relating to Event File--Records, Data Fields and Codes) were provided for the reporting quarter; and

(4) - (5) (No change.)

(d) - (f) (No change.)

[(g) This section is effective 90 calendar days after being published in the *Texas Register.* The department will not implement or enforce this section until July 1, 2009, at the earliest.]

§421.67. Event Files--Records, Data Fields and Codes.

(a) - (c) (No change.)

(d) Facilities shall submit the required minimum data set in the following modified ANSI 837 Institutional Guide format for all patients that are uninsured or considered self-pay or covered by third party payers in which the payer requires the claim be submitted in an ANSI 837 Institutional Guide format or CMS-1450 format for which an event claim is required by this subchapter. The required minimum data set for the modified (as specified in subsection (c) of this section) ANSI 837 Institutional Guide format includes the following data elements as listed in this subsection:

(1) - (32) (No change.)

(33) Service Line Date (effective 90 calendar days after being published in the *Texas Register);*

(34) [(33)] Service Provider Name;

(35) [(34)] Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier;

(36) [(35)] Service Provider Address:

(A) Service Provider Address Line 1;

(B) Service Provider Address Line 2 (if applicable);

(C) Service Provider City;

(D) Service Provider State; and

(E) Service Provider ZIP; and

(37) [(36)] Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility.

(e) (No change.)

(f) Facilities shall submit the required minimum data set to DSHS for each patient who has one or more of the following revenue codes in this subsection or one or more of the outpatient surgical or radiological procedures (which are covered by the service and procedure categories listed in subsection (g) of this section) for services rendered to the patient in the facility. Facilities operating in the State of Texas shall submit the required data elements as specified in subsection (d) or (e) of this section relating to the revenue codes in this subsection or the procedure codes covered in the service and procedure categories listed in subsection (g) of this section.

(1) 0320 Radiology--Diagnostic General Classification. (effective 90 calendar days after being published in the *Texas Register);*

(2) [(1)] 0321 Radiology--Diagnostic Angiocardiology;

(3) [(2)] 0322 Radiology--Diagnostic Arthrography;

(4) [(3)] 0323 Radiology--Diagnostic Arteriography;

(5) [(4)] 0329 Radiology--Diagnostic Other Radiology - Diagnostic;

(6) [(5)] 0330 Radiology--Therapeutic General Classification;

(7) [(6)] 0333 Radiology--Therapeutic Radiation Therapy;

(8) [(7)] 0339 Radiology--Therapeutic Other Radiology - Therapeutic;

(9) [(8)] 0340 Nuclear Medicine General Classification;

(10) [(9)] 0341 Nuclear Medicine Diagnostic;

(11) [(10)] 0342 Nuclear Medicine Therapeutic;

(12) [(11)] 0343 Nuclear Medicine Diagnostic Pharmaceuticals;

(13) [(12)] 0344 Nuclear Medicine Therapeutic Pharmaceuticals;

(14) [(13)] 0349 Nuclear Medicine Other Nuclear Medicine;

(15) [(14)] 0350 Computed Tomography (CT) Scan General Classification;

(16) [(15)] 0351 Computed Tomography (CT)--Head Scan;

(17) [(16)] 0352 Computed Tomography (CT)--Body Scan;

(18) [(17)] 0359 Computed Tomography (CT)--Other;

(19) [(18)] 0360 Operating Room Services General Classification;

(20) [(19)] 0361 Operating Room Services Minor Surgery;

(21) [(20)] 0369 Operating Room Services Other Operating Room Services;

(22) [~~(21)~~] 0400 Other Imaging Services General Classification;

(23) [~~(22)~~] 0401 Other Imaging Services Diagnostic Mammography;

(24) [~~(23)~~] 0403 Other Imaging Services Screening Mammography;

(25) [~~(24)~~] 0404 Other Imaging Services Positron Emission Tomography (PET);

(26) [~~(25)~~] 0409 Other Imaging Services Other Imaging Services;

(27) [~~(26)~~] 0481 Cardiology Cardiac Catheterization Lab;

(28) [~~(27)~~] 0483 Cardiology Echocardiology;

(29) [~~(28)~~] 0489 Cardiology Other Cardiology Services;

(30) [~~(29)~~] 0490 Ambulatory Surgical Care General Classification;

(31) [~~(30)~~] 0499 Ambulatory Surgical Care Other Ambulatory Surgical;

(32) [~~(31)~~] 0500 Outpatient Services General Classification;

(33) [~~(32)~~] 0509 Outpatient Services Other Outpatient;

(34) [~~(33)~~] 0610 Magnetic Resonance Technology General Classification;

(35) [~~(34)~~] 0611 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Brain/Brainstem;

(36) [~~(35)~~] 0612 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Spinal Cord/Spine;

(37) [~~(36)~~] 0614 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Other;

(38) [~~(37)~~] 0615 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Head and Neck;

(39) [~~(38)~~] 0616 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Lower Extremities;

(40) [~~(39)~~] 0618 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Other;

(41) [~~(40)~~] 0619 Magnetic Resonance Technology Other Magnetic Resonance Technology;

(42) [~~(41)~~] 0760 Specialty Room--Treatment/Observation Room General Classification;

(43) [~~(42)~~] 0761 Specialty Room--Treatment Room;

(44) [~~(43)~~] 0762 Specialty Room--Observation Room; and

(45) [~~(44)~~] 0769 Specialty Room--Other Specialty Room.

(g) Service and Procedure Categories. The HCPCS code ranges relating to the surgical and radiological or imaging categories to be reported shall be specified by the department and published on the department website by September 1st of the year prior to the date on which the services are performed.

(1) Incision or excision of Central Nervous System (CNS);

(2) Insertion, replacement, or removal of extracranial ventricular shunt;

(3) Laminectomy, excision intervertebral disc;

(4) Diagnostic spinal tap;

(5) Insertion of catheter or spinal stimulator and injection into spinal canal;

(6) Decompression of peripheral nerves;

(7) Other diagnostic nervous system procedures (requiring surgical or radiological procedures);

(8) Other operating room therapeutic nervous system surgical procedures;

(9) Thyroidectomy, partial or complete;

(10) Diagnostic endocrine procedures (requiring surgical or radiological procedures);

(11) Other therapeutic endocrine procedures (requiring surgical or radiological procedures);

(12) Corneal transplant;

(13) Glaucoma procedures (requiring surgical or radiological procedures);

(14) Lens and cataract procedures (requiring surgical or radiological procedures);

(15) Repair of retinal tear, detachment (requiring surgical or radiological procedures);

(16) Destruction of lesion of retina and choroid (requiring surgical or radiological procedures);

(17) Diagnostic procedures on eye (requiring surgical or radiological procedures);

(18) Other therapeutic procedures on eyelids, conjunctiva, cornea (requiring surgical or radiological procedures);

(19) Other intraocular therapeutic procedures (requiring surgical or radiological procedures);

(20) Other extraocular muscle and orbit therapeutic procedures (requiring surgical or radiological procedures);

(21) Tympanoplasty;

(22) Myringotomy;

(23) Mastoidectomy;

(24) Diagnostic procedures on ear (requiring surgical or radiological procedures);

(25) Other therapeutic ear procedures (requiring surgical or radiological procedures);

(26) Control of epistaxis (requiring surgical or radiological procedures);

(27) Plastic procedures on nose (requiring surgical or radiological procedures);

(28) Oral and Dental Services (requiring surgical or radiological procedures);

(29) Tonsillectomy or adenoidectomy;

(30) Diagnostic procedures on nose, mouth and pharynx (requiring surgical or radiological procedures);

(31) Other non-operating room therapeutic procedures on nose, mouth and pharynx (requiring surgical procedures);

(32) Other operating room therapeutic procedures on nose, mouth and pharynx (requiring surgical or radiological procedures);

(33) Tracheostomy, temporary and permanent;

(34) Tracheoscopy and laryngoscopy with biopsy;

(35) Lobectomy or pneumonectomy;

(36) Diagnostic bronchoscopy and biopsy of bronchus (requiring surgical or radiological procedures);

(37) Other diagnostic procedures on lung and bronchus (requiring surgical or radiological procedures);

(38) Incision of pleura, thoracentesis, chest drainage;

(39) Other diagnostic procedures of respiratory tract and mediastinum (requiring surgical or radiological procedures);

(40) Other non-operating room therapeutic procedures on respiratory system (requiring surgical procedures);

(41) Other operating room therapeutic procedures on respiratory system (requiring surgical or radiological procedures);

(42) Heart valve procedures;

(43) Coronary artery bypass graft (CABG);

(44) Percutaneous transluminal coronary angioplasty (PTCA);

(45) Coronary thrombolysis (requiring surgical or radiological procedures);

(46) Diagnostic Cardiovascular (Cardiac) catheterization, coronary arteriography;

(47) Insertion, revision, replacement, removal of Cardiovascular (Cardiac) pacemaker or cardioverter/defibrillator (requiring surgical or radiological procedures);

(48) Other operating room heart procedures (requiring surgical or radiological procedures);

(49) Extracorporeal circulation auxiliary to open heart procedures (requiring surgical or radiological procedures);

(50) Endarterectomy, vessel of head and neck;

(51) Aortic resection, replacement or anastomosis;

(52) Varicose vein stripping, lower limb;

(53) Other vascular catheterization, not heart;

(54) Peripheral vascular bypass;

(55) Other vascular bypass and shunt, not heart;

(56) Creation, revision and removal of arteriovenous fistula or vessel-to-vessel cannula for dialysis;

(57) Hemodialysis;

(58) Other operating room procedures on vessels of head and neck (requiring surgical or radiological procedures);

(59) Embolectomy and endarterectomy of lower limbs (requiring surgical or radiological procedures);

(60) Other operating room procedures on vessels other than head and neck (requiring surgical or radiological procedures);

(61) Other diagnostic cardiovascular procedures (requiring surgical or radiological procedures);

(62) Other non-operating room therapeutic cardiovascular procedures (requiring surgical or radiological procedures);

(63) Bone marrow transplant;

(64) Bone marrow biopsy;

(65) Procedures on spleen (requiring surgical or radiological procedures);

(66) Other therapeutic procedures, hemic or lymphatic system (requiring surgical or radiological procedures);

(67) Ligation of esophageal varices;

(68) Esophageal dilatation (requiring surgical or radiological procedures);

(69) Upper gastrointestinal endoscopy, biopsy;

(70) Gastrostomy, temporary or permanent;

(71) Colostomy, temporary or permanent;

(72) Ileostomy and other enterostomy;

(73) Gastrectomy, partial or total;

(74) Small bowel resection;

(75) Colonoscopy or biopsy;

(76) Proctoscopy or anorectal biopsy;

(77) Colorectal resection;

(78) Local excision of large intestine lesion (not endoscopic);

(79) Appendectomy;

(80) Hemorrhoid procedures (requiring surgical or radiological procedures);

(81) Endoscopic retrograde cannulation of pancreas (ERCP);

(82) Biopsy of liver;

(83) Cholecystectomy or common duct exploration (requiring surgical or radiological procedures);

(84) Inguinal or femoral hernia repair (requiring surgical or radiological procedures);

(85) Other hernia repair (requiring surgical or radiological procedures);

(86) Laparoscopy;

(87) Abdominal paracentesis;

(88) Exploratory laparotomy;

(89) Excision, lysis peritoneal adhesions (requiring surgical or radiological procedures);

(90) Other bowel diagnostic procedures (requiring surgical or radiological procedures);

(91) Other non-operating room upper GI therapeutic procedures (requiring surgical or radiological procedures);

(92) Other operating room upper GI therapeutic procedures (requiring surgical or radiological procedures);

(93) Other non-operating room lower GI therapeutic procedures (requiring surgical or radiological procedures);

(94) Other operating room lower GI therapeutic procedures (requiring surgical or radiological procedures);

(95) Other gastrointestinal diagnostic procedures (requiring surgical or radiological procedures);

(96) Other non-operating room gastrointestinal therapeutic procedures (requiring surgical or radiological procedures);

(97) Other operating room gastrointestinal therapeutic procedures (requiring surgical or radiological procedures);

(98) Endoscopy or endoscopic biopsy of the urinary tract;

(99) Transurethral excision, drainage, or removal urinary obstruction (requiring surgical or radiological procedures);

(100) Ureteral catheterization;

(101) Nephrotomy or nephrostomy;

(102) Nephrectomy, partial or complete;

(103) Kidney transplant;

(104) Genitourinary incontinence procedures (requiring surgical or radiological procedures);

(105) Extracorporeal lithotripsy, urinary (requiring surgical or radiological procedures);

(106) Indwelling catheter;

(107) Procedures on the urethra (requiring surgical or radiological procedures);

(108) Other diagnostic procedures of urinary tract (requiring surgical or radiological procedures);

(109) Other non-operating room therapeutic procedures of urinary tract (requiring surgical or radiological procedures);

(110) Other operating room therapeutic procedures of urinary tract (requiring surgical or radiological procedures);

(111) Transurethral resection of prostate (TURP);

(112) Open prostatectomy;

(113) Circumcision;

(114) Diagnostic procedures, male genital (requiring surgical or radiological procedures);

(115) Other non-operating room therapeutic procedures, male genital (requiring surgical or radiological procedures);

(116) Other operating room therapeutic procedures, male genital (requiring surgical or radiological procedures);

(117) Oophorectomy, unilateral or bilateral;

(118) Other operations on ovary (requiring surgical or radiological procedures);

(119) Ligation of fallopian tubes (requiring surgical or radiological procedures);

(120) Removal of ectopic pregnancy (requiring surgical or radiological procedures);

(121) Other operations on fallopian tubes (requiring surgical or radiological procedures);

(122) Hysterectomy, abdominal or vaginal (requiring surgical or radiological procedures);

(123) Other excision of cervix or uterus;

(124) Abortion (termination of pregnancy);

(125) Dilatation and curettage (D&C), aspiration after delivery or abortion (requiring surgical or radiological procedures);

(126) Diagnostic dilatation and curettage (D&C);

(127) Repair of cystocele or rectocele, obliteration of vaginal vault (requiring surgical or radiological procedures);

(128) Other diagnostic procedures, female organs (requiring surgical or radiological procedures);

(129) Other non-operating room therapeutic procedures, female organs (requiring surgical or radiological procedures);

(130) Other operating room therapeutic procedures, female organs (requiring surgical or radiological procedures);

(131) Episiotomy;

(132) Cesarean section;

(133) Forceps, vacuum, or breech delivery (requiring surgical or radiological procedures);

(134) Artificial Rupture of membranes to assist delivery (requiring surgical procedures);

(135) Other procedures to assist delivery (requiring surgical or radiological procedures);

(136) Diagnostic amniocentesis;

(137) Fetal monitoring (requiring surgical or radiological procedures);

(138) Repair of current obstetric laceration;

(139) Other therapeutic obstetrical procedures (requiring surgical or radiological procedures);

(140) Partial excision bone;

(141) Bunionectomy or repair of toe deformities (requiring surgical or radiological procedures);

(142) Treatment, facial fracture or dislocation (requiring surgical or radiological procedures);

(143) Treatment, fracture or dislocation of radius and ulna (requiring surgical or radiological procedures);

(144) Treatment, fracture or dislocation of hip and femur (requiring surgical or radiological procedures);

(145) Treatment, fracture or dislocation of lower extremity (other than hip or femur) (requiring surgical or radiological procedures);

(146) Other fracture and dislocation procedure (requiring surgical or radiological procedures);

(147) Arthroscopy;

(148) Division of joint capsule, ligament or cartilage;

(149) Excision of semilunar cartilage of knee;

(150) Arthroplasty knee;

(151) Hip replacement, total or partial;

(152) Arthroplasty other than hip or knee;

(153) Arthrocentesis;

(154) Injections and aspirations of muscles, tendons, bursa, joints and soft tissue (requiring surgical or radiological procedures);

(155) Amputation of lower extremity;

(156) Spinal fusion (requiring surgical or radiological procedures);

(157) Other diagnostic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(158) Other therapeutic procedures on muscles and tendons (requiring surgical or radiological procedures);

(159) Other operating room therapeutic procedures on bone (requiring surgical or radiological procedures);

(160) Other operating room therapeutic procedures on joints (requiring surgical or radiological procedures);

(161) Other non-operating room therapeutic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(162) Other operating room therapeutic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(163) Breast biopsy or other diagnostic procedures on breast (requiring surgical or radiological procedures);

(164) Lumpectomy, quadrantectomy of breast;

(165) Mastectomy;

(166) Incision and drainage, skin and subcutaneous tissue (requiring surgical or radiological procedures);

(167) Excision of skin lesion;

(168) Suture of skin or subcutaneous tissue;

(169) Skin graft;

(170) Other diagnostic procedures on skin or subcutaneous tissue;

(171) Other non-operating room therapeutic procedures on skin or breast (requiring surgical or radiological procedures);

(172) Other operating room therapeutic procedures on skin or breast (requiring surgical or radiological procedures);

(173) Other organ transplantation;

(174) Computerized axial tomography (CT) scan head;

(175) Computerized axial tomography (CT) scan chest;

(176) Computerized axial tomography (CT) scan abdomen;

(177) Other Computerized axial tomography (CT) scan;

(178) Myelogram;

(179) Mammography;

(180) Routine chest X-ray;

(181) Intraoperative cholangiogram;

(182) Upper gastrointestinal X-ray;

(183) Lower gastrointestinal X-ray;

(184) Intravenous pyelogram;

(185) Cerebral arteriogram;

(186) Contrast aortogram;

(187) Contrast arteriogram of femoral or lower extremity arteries;

(188) Arteriogram or venogram (not heart or head);

(189) Diagnostic ultrasound of head or neck;

(190) Diagnostic ultrasound of heart (echocardiogram);

(191) Diagnostic ultrasound of gastrointestinal tract;

(192) Diagnostic ultrasound of urinary tract;

(193) Diagnostic ultrasound of abdomen or retroperitoneum;

(194) Other diagnostic ultrasound;

(195) Magnetic resonance imaging;

(196) Electroencephalogram (EEG) (requiring surgical or radiological procedures);

(197) Swan-Ganz catheterization for monitoring;

(198) Radioisotope bone scan;

(199) Radioisotope pulmonary scan;

(200) Radioisotope scan or function studies;

(201) Other radioisotope scan;

(202) Therapeutic Radiology;

(203) Traction, splints, or other wound care (requiring surgical or radiological procedures);

(204) Ophthalmologic or otologic diagnosis and treatment (requiring surgical or radiological procedures);

(205) Nasogastric tube (requiring radiological procedures);

(206) Blood transfusion;

(207) Parenteral nutrition (via intravenous methods);

(208) Cancer chemotherapy (requiring surgical or radiological procedures);

(209) Conversion of Cardiovascular (Cardiac) rhythm;

(210) Other diagnostic radiology and related (requiring surgical or radiological procedures);

(211) Other therapeutic procedures (requiring surgical or radiological procedures);

(212) Infertility Services (requiring surgical or radiological procedures);

(213) Medications (Infusions and other forms requiring surgical or radiological procedures); and

(214) Gastric bypass and volume reduction (requiring surgical or radiological procedures).

(h) [~~(g)~~] This section is effective 90 calendar days after being published in the *Texas Register.* The department will not implement or enforce this section until September 1, 2011 [~~July 1, 2009~~], at the earliest.

§421.68. Event Data Release.

(a) DSHS records are public records under Government Code, Chapter 552, except as specifically exempted by Health and Safety Code, §§108.010, 108.011 and 108.013 or other state or federal law. Copies of such records may be obtained upon request and upon payment of user fees established by DSHS. The public use data file shall be available for public inspection during normal business hours. Event claims in any [~~the original~~] format as submitted to DSHS are not available to the public[~~, are not stored at DSHS~~] and are exempt from disclosure pursuant to Health and Safety Code, §§108.010, 108.011 and 108.013, and shall not be released. Likewise, patient and physician identifying data collected by the DSHS through editing of facility data shall not be released.

(b) - (i) (No change.)

~~[(j) This section is effective 90 calendar days after being published in the *Texas Register.* The department will not implement or enforce this section until July 1, 2009 at the earliest.]~~

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101350
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 458-7111 x6972

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER H. PUBLIC LANDS PROCLAMATION

31 TAC §65.190, §65.191

The Texas Parks and Wildlife Department proposes amendments to §65.190 and §65.191, concerning the Public Lands Proclamation. The proposed amendment to §65.190, concerning Application, would add "Blue Elbow Swamp-Tony Houseman WMA/SP" to the list of wildlife public hunting lands contained in the section. The area was acquired in 1997 but inadvertently was not included in the inventory of public hunting lands listed in the section.

The proposed amendment to §65.191, concerning Definitions, would add definitions of "airboat" and "motorboat." Advances in propulsion systems technology (belt drives, mud pumps, etc.) have increased the ability of shallow-draft vessels to operate in very shallow waters and wetlands, which poses threats to habitats on WMAs as a result of the physical disturbance of soils and vegetation. Current rules prohibit the use of airboats on WMAs except by executive order or written permission, and several WMAs impose site-specific restrictions on the operation of motorboats; however, the terms "airboat" and "motorboat" are not defined by rule. The proposed amendment would supply a regulatory meaning for each of those terms for enforcement purposes. By clearly defining what is meant by those terms, the department's existing regulations regarding public access and use can be enforced without ambiguity.

Ms. Linda Campbell, Public Hunting and Private Lands program director, has determined that for each of the first five years that the rules as proposed are in effect, there will be no fiscal implications to state and local governments as a result of enforcing or administering the rules.

Ms. Campbell also has determined that for each of the first five years the rules as proposed are in effect, the public benefit anticipated as a result of enforcing or administering the rules as proposed will be accurate references and clear definitions within department regulations.

There will be no adverse economic effect on persons required to comply with the rules as proposed.

Under the provisions of Government Code, Chapter 2006, a state agency must prepare an economic impact statement and a regulatory flexibility analysis for a rule that may have an adverse economic effect affect on small businesses and micro-businesses. As required by Government Code, §2006.002(g), the Office of the Attorney General has prepared guidelines to assist state agencies in determining a proposed rule's potential adverse economic impact on small businesses. Those guidelines state that an agency need only consider a proposed rule's "direct adverse economic impacts" to small businesses and micro-businesses to determine if any further analysis is required. For that purpose, the department considers "direct economic impact" to mean a requirement that would directly impose recordkeeping or reporting requirements; impose taxes or fees; result in lost sales or profits; adversely affect market competition; or require the purchase or modification of equipment or services. Since the proposed rules do not affect small businesses or microbusinesses, the department has determined that the proposed amendment will not impose any direct adverse economic effects on small businesses or microbusinesses. Accordingly, the department has not prepared a regulatory flexibility analysis under Government Code, Chapter 2006.

The department has not drafted a local employment impact statement under the Administrative Procedures Act, §2001.022, as the agency has determined that the rules as proposed will not impact local economies.

The department has determined that there will not be a taking of private real property, as defined by Government Code, Chapter 2007, as a result of the proposed rules.

Comments on the proposed rules may be submitted to Linda Campbell, Texas Parks and Wildlife Department 4200 Smith School Road, Austin, Texas 78744; (512) 389-4395 (e-mail: linda.campbell@tpwd.state.tx.us).

The amendments are proposed under the authority of Parks and Wildlife Code, Chapter 81, Subchapter E, which authorizes the Parks and Wildlife Commission to promulgate rules governing access to and use of public hunting lands and specific hunting, fishing, recreational, or other use of wildlife management areas and requires the commission to prescribe by rule any terms, conditions, and fees for the issuance and use of permits.

The proposed amendments affect Parks and Wildlife Code, Chapter 81, Subchapter E.

§65.190. Application.

(a) This subchapter applies to all activities subject to department regulation on lands designated by the department as public hunting lands, regardless of the presence or absence of boundary markers. Public hunting lands are acquired by lease or license, management agreements, trade, gift, and purchase. Records of such acquisition are on file at the Department's central repository.

(b) On U.S. Forest Service Lands designated as public hunting lands (Alabama Creek, Bannister, Caddo, Lake McClellan Recreation Area, Moore Plantation, and Sam Houston National Forest WMAs) or any portion of Units 902 and 903, persons other than hunters are exempt from the provisions of this subchapter, except for the provisions of §65.199(15) of this title (relating to General Rules of Conduct).

(c) On U.S. Army Corps of Engineer Lands designated as public hunting lands (Cooper, Dam B, Granger, Pat Mayse, Ray Roberts, Somerville, and White Oak Creek WMAs), persons other than hunters and equestrian users are exempt from requirements for an access permit.

(d) On state park lands designated as public hunting lands, access for fishing and recreational use is governed by state park regulations.

(e) Public hunting lands include, but are not limited to, the following:

(1) Alabama Creek WMA (Unit 904);

(2) Alazan Bayou WMA (Unit 747);

(3) Atkinson Island WMA;

(4) Bannister WMA (Unit 903);

(5) Big Lake Bottom WMA (Unit 733);

(6) Black Gap WMA (Unit 701);

(7) Blue Elbow Swamp-Tony Houseman WMA/SP;

(8) [~~(7)~~] Caddo Lake WMA (Unit 730);

(9) [~~(8)~~] Caddo National Grasslands WMA (Unit 901);

(10) [~~(9)~~] Candy Abshier WMA;

(11) [~~(10)~~] Cedar Creek Islands WMA (includes Big Island, Bird Island, and Telfair Island Units);

(12) [~~(11)~~] Chaparral WMA (Unit 700);

(13) [~~(12)~~] Cooper WMA (Unit 731);

(14) [~~(13)~~] D.R. Wintermann WMA;

(15) [~~(14)~~] Dam B WMA--includes Angelina-Neches Scientific Area (Unit 707);

(16) [~~(15)~~] Designated Units of the Las Palomas WMA;

(17) [~~(16)~~] Designated Units of Public Hunting Lands Under Short-Term Lease;

(18) [~~(17)~~] Designated Units of the Playa Lakes WMA;

(19) [~~(18)~~] Designated Units of the State Park System;

(20) [~~(19)~~] Elephant Mountain WMA (Unit 725);

(21) [~~(20)~~] Gene Howe WMA (Unit 755)--includes Pat Murphy Unit (Unit 706);

(22) [~~(21)~~] Granger WMA (Unit 709);

(23) [~~(22)~~] Guadalupe Delta WMA (Unit 729)--includes Mission Lake Unit (720), Guadalupe River Unit (723), Hynes Bay Unit (724), and San Antonio River Unit (760);

(24) [~~(23)~~] Gus Engeling WMA (Unit 754);

(25) [~~(24)~~] James Daughtrey WMA (Unit 713);

(26) [~~(25)~~] J.D. Murphree WMA (Unit 783);

(27) [~~(26)~~] Justin Hurst WMA (Unit 721);

(28) [~~(27)~~] Keechi Creek WMA (Unit 726);

(29) [~~(28)~~] Kerr WMA (Unit 756);

(30) [~~(29)~~] Lake McClellan Recreation Area (Unit 906);

(31) [~~(30)~~] Lower Neches WMA (Unit 728)--includes Old River Unit and Nelda Stark Unit;

(32) [~~(31)~~] Mad Island WMA (Unit 729);

(33) [~~(32)~~] Mason Mountain WMA (Unit 749);

(34) [~~(33)~~] Matador WMA (Unit 702);

(35) [~~(34)~~] Matagorda Island WMA (Unit 722);

(36) [~~(35)~~] McGillvray and Leona McKie Muse WMA (Unit 750);

(37) [~~(36)~~] M.O. Neasloney WMA;

(38) [~~(37)~~] Moore Plantation WMA (Unit 902);

(39) [~~(38)~~] Nannie Stringfellow WMA (Unit 716);

(40) [~~(39)~~] North Toledo Bend WMA (Unit 615);

(41) [~~(40)~~] Old Sabine Bottom WMA (Unit 732);

(42) [~~(41)~~] Old Tunnel WMA;

(43) [~~(42)~~] Pat Mayse WMA (Unit 705);

(44) [~~(43)~~] Ray Roberts WMA (Unit 501);

(45) [~~(44)~~] Redhead Pond WMA;

(46) [~~(45)~~] Richland Creek WMA (Unit 703);

(47) [~~(46)~~] Sam Houston National Forest WMA (Unit 905);

(48) [~~(47)~~] Sierra Diablo WMA (Unit 767);

(49) [~~(48)~~] Somerville WMA (Unit 711);

(50) [~~(49)~~] Tawakoni WMA (Unit 708);

(51) [~~(50)~~] Walter Buck WMA (Unit 757);

(52) [~~(51)~~] Welder Flats WMA;

(53) [~~(52)~~] White Oak Creek WMA (Unit 727); and

(54) [~~(53)~~] Other numbered units of public hunting lands.

§65.191. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise. All other words and terms shall have the meanings assigned in §65.3 of this title (relating to Statewide Hunting and Fishing Proclamation).

(1) Adult--A person 17 years of age or older.

(2) Airboat--A boat propelled mechanically by movement of air, including, but not limited to a fan, propeller, or jet.

(3) [~~(2)~~] All terrain vehicle (ATV)--Any vehicle meeting the definition of an ATV under Transportation Code, §663.001.

(4) [~~(3)~~] Annual Public Hunting (APH) Permit--A permit, valid from issuance date through the following August 31, which allows entry to designated public hunting lands at designated times and the taking of wildlife resources as designated.

(5) [~~(4)~~] Application fee--A non-refundable fee that may be required to accompany and validate an individual's application for a special permit.

(6) [~~(5)~~] Authorized supervising adult--A parent, legal guardian, or individual at least 18 years of age who assumes liability responsibility for a youth.

(7) [~~(6)~~] Blind--Any structure assembled of man-made or natural materials for the purpose or having the effect of promoting concealment or increasing the field of vision of a person.

(8) [~~(7)~~] Buckshot--Lead pellets ranging in size from .24-inch to .36-inch in diameter normally loaded in a shotgun (includes, but is not limited to 0 and 00 buckshot).

(9) [~~(8)~~] Camping--The use of public hunting lands for overnight accommodation, which includes sleeping, the storage of unattended personal possessions, or the use of a motor vehicle as a lodging.

(10) [~~(9)~~] Competitive hunting dog event (field trial)--A department-sanctioned contest in which the skills of hunting dogs are tested.

(11) [~~(10)~~] Concurrent hunt--A hunt that maintains the same permit requirements, hunt dates, means and methods, or shooting hours or combinations thereof for more than one species of animal, as designated and subject to any special provisions.

(12) [~~(11)~~] Consumptive user--A person who takes or attempts to take wildlife resources.

(13) [~~(12)~~] Designated campsite--A designated area where camping and camping activities are authorized.

(14) [~~(13)~~] Designated days--Specific days within an established season or period of time as designated by the executive director.

(15) [~~(14)~~] Designated road--A constructed roadway indicated as being open to the public by either signs posted to that effect or by current maps and leaflets distributed at the area. Roads closed to the public may additionally be identified by on-site signing, barricades at entrances, or informational literature made available to the public. Designated roads do not include county or state roads or highways.

(16) [~~(15)~~] Designated target practice area--An area designated by on-site signing or by order of the executive director within which the discharge of firearms for target practice is authorized.

(17) [~~(16)~~] Designated units of the state park system--Specific units of the state park system approved by the commission for application of provisions of this subchapter.

(18) [~~(17)~~] Disabled person--A person who possesses a placard, license plate, or other documentation issued to that person by the State of Texas under the provisions of Transportation Code, Chapter 681.

(19) [~~(18)~~] General Season--A specified time period, or designated days within a specified time period, during which more than one means or methods (as designated) may be used to take designated species.

(20) [~~(19)~~] Headwear--Garment or item of apparel worn on or about the head.

(21) [~~(20)~~] Immediate supervision--Control of a youth by an authorized supervising adult issuing verbal instructions in a normal voice level.

(22) [~~(21)~~] Lands within a desert bighorn sheep cooperative--An aggregation of lands for which the concerned landowners and the Texas Parks and Wildlife Department have agreed to coordinate efforts to restore, manage, and harvest desert bighorn sheep.

(23) [~~(22)~~] Limited Public Use (LPU) Permit--A permit, valid from issuance date through the following August 31, which allows access to designated wildlife management areas and public hunting lands at the same times that access is provided by an APH permit.

(24) [~~(23)~~] Limited use zone--An area designated by order of the executive director and/or by boundary signs on the area, within which public use is prohibited or restricted to specified activities.

(25) [~~(24)~~] Loaded firearm--A firearm containing a live round of ammunition within the chamber and/or the magazine, or if muzzleloading, one which has a cap on the nipple or a priming charge in the pan.

(26) [~~(25)~~] Mentored Hunting Permit--A permit authorizing access to public hunting lands for the purpose of attending a department-sponsored workshop, including participation in a designated hunting opportunity subsequent to the workshop.

(27) Motorboat--Any vessel being propelled by machinery, but does not include a boat being propelled solely by paddle, pole, oar, or wind.

(28) [~~(26)~~] Motor vehicle--As defined by Transportation Code, Chapter 541.

(29) [~~(27)~~] Off-road vehicle--An ATV, a utility vehicle, a vehicle that may not lawfully be operated on a public roadway, or any vehicle that is manufactured or adapted for off-road use.

(30) [~~(28)~~] On-site registration--The requirement for public users to register at designated places upon entry to and exit from specified public hunting lands, but does not constitute a permit.

(31) [~~(29)~~] Permit--Documentation authorizing specified access and public use privileges on public hunting lands.

(32) [~~(30)~~] Predatory animals--Coyotes and bobcats.

(33) [~~(31)~~] Preference point system--A method of special permit distribution in which the probability of selection is progressively enhanced by prior unsuccessful applications within a given hunt category by individuals or groups.

(34) [~~(32)~~] Public hunting area--A portion of public hunting lands designated as being open to the activity of hunting, and may include all or only a portion of a certain unit of public hunting land.

(35) [~~(33)~~] Public hunting compartment--A defined portion of a public hunting area to which hunters are assigned and authorized to perform public hunting activity.

(36) [~~(34)~~] Public hunting lands--Lands identified in §65.190 of this title (relating to Application) or by order of the executive director on which provisions of this subchapter apply.

(37) [~~(35)~~] Recreational use--Any use or activity other than hunting or fishing.

(38) [~~(36)~~] Regular Permit--A permit issued on a first-come-first-served basis, on-site, at the time of the hunt that allows the taking of designated species of wildlife on the issuing area.

(39) [~~(37)~~] Restricted area--All or portions of public hunting lands identified by boundary signs as being closed to public entry or use.

(40) [~~(38)~~] Sanctuary--All or a portion of public hunting lands identified by boundary sign as being closed to the hunting of specified wildlife resources.

(41) [~~(39)~~] Slug--A metallic object designed for being fired as a single projectile by discharge of a shotgun.

(42) [~~(40)~~] Special Access Permit--A permit, issued pursuant to a selection procedure, that allows access to a specified unit of the state park system at a specified time.

(43) [~~(41)~~] Special Permit--A permit, issued pursuant to a selection procedure, which allows the taking of designated species of wildlife.

(44) [~~(42)~~] Special package hunt--A public hunt conducted for promotional or fund raising purposes and offering the selected applicant(s) a high quality experience with enhanced provisions for food, lodging, transportation, and guide services.

(45) [~~(43)~~] Tagging fee--A fee which may be assessed in addition to the special permit fee for the harvest of alligators for commercial sale or prior to the attempted harvest of desert bighorn sheep or designated exotic mammals.

(46) [~~(44)~~] Wildlife management area (WMA)--A unit of public hunting lands which is intensively managed for the conservation, enhancement, and public use of wildlife resources and supporting habitats.

(47) [~~(45)~~] Wildlife resources--Game animals, game birds, furbearing animals, alligators, marine mammals, frogs, fish, crayfish, other aquatic life, exotic animals, predatory animals, rabbits and hares, and other wild fauna.

(48) [~~(46)~~] Wounded exotic mammal--An exotic mammal leaving a blood trail.

(49) [~~(47)~~] Youth--A person less than 17 years of age.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101349
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 389-4775

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TITLE 34. PUBLIC FINANCE

PART 4. EMPLOYEES RETIREMENT SYSTEM OF TEXAS

CHAPTER 73. BENEFITS

34 TAC §73.25

The Employees Retirement System of Texas (ERS) proposes amendments to 34 Texas Administrative Code (TAC) §73.25, concerning Payment to an Estate.

Section 73.25 is being amended to increase the amount that may be payable to $7,500 to ease the payment of claims when formal documentation will be difficult for beneficiaries or heirs to obtain. Upon the death of an ERS annuitant, the annuitant's designated beneficiary is entitled to receive a $5,000 lump sum death benefit. This benefit is in addition to any remaining retirement benefits due the deceased annuitant. Currently, §73.25 requires letters testamentary, an order admitting a will to probate as muniment of title, an affidavit filed with the county court under the small estates provisions of the Texas Probate Code §137, or a judgment to declare heirship to make a payment to an estate of more than $5,000. Occasionally, ERS members or annuitants pass away without designating beneficiaries, updating beneficiaries or completing the process of adding beneficiaries. These are just some examples of situations where the system may have a payment owed to an estate due to a member's or annuitant's death. Quite often, if an annuitant was owed any remaining retirement annuity, when added to the $5,000 lump sum death benefit, it will exceed the $5,000 currently in the rule and the estate or heirs would be required to obtain the necessary formal documentation in order to claim the funds. The estate and heirs are often reluctant to enter into a potentially complicated and expensive probate proceeding for the sole purpose of recovering the benefits for an amount of that size. ERS will continue to obtain releases and indemnification agreements and other appropriate documentation before making such payments.

Ms. Paula A. Jones, General Counsel and Chief Compliance Officer, has determined that for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule, and, to her knowledge, small businesses should not be affected.

Ms. Jones also determined that for each year of the first five years the rule is in effect the public benefit anticipated as a result of enforcing the rule would be to simplify administration for the ERS defined benefit plans, and to ease the burden on the estates or heirs of members or annuitants regarding the payment of small claims while maintaining the security of the retirement trust fund. There are no known anticipated economic costs to persons who are required to comply with the rule as proposed.

Comments on the proposed rule amendments may be submitted to Paula A. Jones, General Counsel and Chief Compliance Officer, Employees Retirement System of Texas, P.O. Box 13207, Austin, Texas 78711-3207, or you may email Ms. Jones at paula.jones@ers.state.tx.us. The deadline for receiving comments is Monday, May 23, 2011, at 8:00 a.m.

The amendments are proposed under Texas Government Code §815.102, which provides authorization for the ERS Board of Trustees to adopt rules for the retirement system for the administration of funds and the transaction of any other business of the system.

No other statutes are affected by the proposed amendments.

§73.25. Payment to an Estate.

(a) Payment due to an estate will be made upon receipt of a certified copy of one of the following:

(1) letters testamentary which are issued to a person named executor or administrator of an estate;

(2) an order admitting a will to probate as muniment of title;

(3) an affidavit filed with the county court under the small estates provisions of the Texas Probate Code §137;

(4) a judgment to declare heirship under the provisions of the Texas Probate Code §54.

(b) If none of the requirements in subsection (a) of this section have been or will be obtained and the amount payable is $7,500 [~~$5,000~~] or less, then payment may be made to the estate of the decedent at his or her last known address or in care of a member of the decedent's family; or in the alternative, payment may be made in accordance with other documentation supplied by the heirs, provided the retirement system has reviewed and approved the documentation and obtained satisfactory releases from the heirs.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 7, 2011.

TRD-201101344
Paula A. Jones
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 867-7421

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CHAPTER 85. FLEXIBLE BENEFITS

34 TAC §85.5

The Employees Retirement System of Texas (ERS) proposes amendments to 34 Texas Administrative Code (TAC) §85.5, concerning Benefits.

Section 85.5 is being amended to simplify administration and to update the rule to conform to federal tax law. Some amendments to the Internal Revenue Code have affected the administration and management of a Flexible Spending Account (FSA). These changes are required in order that the FSA administered by ERS will remain compliant with the Internal Revenue Code.

Section 85.5 is amended to set an individual's yearly FSA contribution limit at the same rate permitted under the Internal Revenue Code and to set a maximum overall limit that is the same as the current limit for participants in the TexFlex FSA program.

Ms. Paula A. Jones, General Counsel and Chief Compliance Officer, has determined that for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule. To Ms. Jones' knowledge, there are no known anticipated economic costs to persons who are required to comply with the rule as proposed, except for any costs associated with continued participation in the TexFlex FSA program, and small businesses should not be affected.

Ms. Jones also determined that for each year of the first five years the rule is in effect the public benefit anticipated as a result of enforcing the rule would be to simplify administration for the ERS FSA plan, and to conform the rule to federal law.

Comments on the proposed rule amendments may be submitted to Paula A. Jones, General Counsel and Chief Compliance Officer, Employees Retirement System of Texas, P.O. Box 13207, Austin, Texas 78711-3207, or you may email Ms. Jones at paula.jones@ers.state.tx.us. The deadline for receiving comments is Monday, May 23, 2011, at 8:00 a.m.

The amendments are proposed under Texas Insurance Code §1551.052 and §1551.206, which provide authorization for the ERS Board of Trustees to adopt rules necessary to carry out its statutory duties and responsibilities to implement the Texas Employees Group Benefits Act and to implement and administer a cafeteria plan.

No other statutes are affected by the proposed amendments.

§85.5. Benefits.

(a) Benefits available for selection by participants. A participant may elect, in accordance with the procedures set forth in this section, one or both of the following benefits, subject to all the requirements and conditions contained in these rules:

(1) health care reimbursement plan;

(2) dependent care reimbursement plan.

(b) Health care reimbursement plan.

(1) Pursuant to the health care reimbursement plan, a participant may elect to receive reimbursements of certain health care expenses which are excludable from the participant's taxable income. The health care reimbursement plan is intended to be qualified under the Code, §105, is an optional benefit under the flexible benefits plan, and constitutes a separate written employee benefit plan as contemplated by the Code, §105, and Treasury Regulation 1.105-11.

(2) Maximum benefit available. Subject to the limitations set forth in these rules, hereafter referred to as the plan, to avoid discrimination, the maximum amount of flexible benefit dollars that an employee may receive in any plan year for health care expenses under the health care reimbursement plan is the amount permitted under the Code, §105. Even if permitted under the Code, in no event shall the amount available exceed $5,000 in a plan year. [~~$5,000. Except as otherwise provided in this paragraph, the monthly maximum salary reduction amount, exclusive of any administrative fees, may not exceed $416 per month.~~] An employee may prepay the health care election amounts for the remainder of the plan year in anticipation of termination, retirement, or a period of leave without pay. [~~An employee classified as a nine-month employee and who receives compensation in fewer than 12 months shall redirect the annual election amount in nine equal monthly amounts of $555, or if married and filing a separate income tax return, of $277.~~]

(c) Dependent care reimbursement plan.

(1) Pursuant to the dependent care reimbursement plan, a participant may elect to have payments made or receive reimbursement for dependent care expenses. The dependent care reimbursement plan is intended to be qualified under the Code, §129, is an optional benefit under the flexible benefits plan, and constitutes a separate written employee benefit plan as contemplated by the Code, §129.

(2) Maximum benefit available.

(A) Subject to any limitations imposed by these rules, hereafter referred to as the plan, to avoid discrimination, the maximum amount that an employee may receive in any plan year in the form of payment of or reimbursement for dependent care expenses under the dependent care reimbursement plan is the lesser of:

(i) the employee's earned income for the plan year (after all reductions in compensation including the reduction related to dependent care expenses);

(ii) the earned income of the employee's spouse for the plan year; or

(iii) the amount permitted under the Code, §129. Even if permitted under the Code, in no event shall the amount available exceed $5,000 in a plan year. [~~$5,000. ($2,500 in the case of a married employee who files a separate federal income tax return.) Except as otherwise provided in this clause, the monthly maximum salary reduction amount, exclusive of any administrative fees, may not exceed $416 per month or $208 per month in the case of a married employee who files a separate federal income tax return. An employee classified as a nine-month employee and who receives annual compensation in fewer than 12 months shall redirect the election amount in nine equal monthly amounts of $555, or if married and filing a separate income tax return, of $277.~~]

(B) In the case of a participant's spouse who is a full-time student at an educational institution or who is physically or mentally incapable of caring for himself, such spouse shall be deemed to have earned income of not less than $200 per month if the participant

has one dependent and $400 per month if the participant has two or more dependents in accordance with the Code, §21.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on April 6, 2011.

TRD-201101342

Paula A. Jones
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Earliest possible date of adoption: May 22, 2011
For further information, please call: (512) 867-7421

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 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 265. GENERAL SANITATION

SUBCHAPTER D. MINIMUM ACCEPTABLE OPERATING STANDARDS FOR WATER SYSTEMS SERVING CAMPS

25 TAC §§265.51 - 265.61

The Executive Commissioner of the Health and Human Services Commission (commission), on behalf of the Department of State Health Services (department), adopts the repeal of §§265.51 - 265.61, concerning the minimum acceptable operating standards for water systems serving camps without changes to the proposal as published in the January 7, 2011, issue of the *Texas Register* (36 TexReg 24), and the sections will not be republished.

BACKGROUND AND PURPOSE

The Texas Youth Camp Safety and Health Act, Health and Safety Code, Chapter 141, requires the department to develop health and safety standards for youth camp water supplies. The Texas Commission on Environmental Quality regulates public water systems serving youth camps. The repeal of the rules is a result of changes incorporated into the amended Texas youth camps safety and health rule, which included operating standards for private water supplies at youth camps. The amendments to 25 TAC §265.13, were in response to recommendations made by the Youth Camp Advisory Committee, as well as by state program personnel based on statutory authority found in the Texas Youth Camp Safety and Health Act, Health and Safety Code, Chapter 141.

SECTION-BY-SECTION SUMMARY

The repeal of §§265.51 - 265.61 is in response to changes in §265.13(r) that were effective in May 2010, establishing current operating standards for private water supplies at youth camps. The repeals will eliminate duplication concerning water standards for youth camps in the rules.

COMMENTS

The department, on behalf of the commission, did not receive any comments regarding the proposed repeals during the comment period.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the repeals, as adopted, have been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

STATUTORY AUTHORITY

The repeals are authorized by Health and Safety Code, §141.008, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules to implement the Youth Camp Safety and Health Act; and by Government Code, §531.0055, and Health and Safety Code §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101360
Lisa Hernandez
General Counsel
Department of State Health Services
Effective date: April 28, 2011
Proposal publication date: January 7, 2011
For further information, please call: (512) 458-7111 x6972

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 363. FINANCIAL ASSISTANCE PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

The Texas Water Development Board ("TWDB" or "Board") adopts amendments pertaining to Chapter 363, §363.12 and §363.31, concerning Financial Assistance Programs, without changes to the proposed text as published in the February 25, 2011, issue of the *Texas Register* (36 TexReg 1240).

The amendments are adopted in order to require information from an applicant for financial assistance about other sources of funding for the project, and to disapprove a commitment to an applicant for financial assistance if federal funds have been obligated for the same project by the United States Department of Agriculture-Rural Development ("USDA-RD").

SECTION BY SECTION DISCUSSION OF THE ADOPTED AMENDMENTS.

§363.12. General, Legal, and Fiscal Information.

The adopted amendment to §363.12 adds to the required information in an application for financial assistance that if additional funds are necessary to complete the project, or if the applicant has applied for and/or received a commitment from any other funding source for the project or any aspect of the project, an applicant shall submit a listing of those sources, including total project costs, financing terms, and current status of the funding requests. The TWDB application already requires this information, so the adopted rule documents a current procedure.

§363.31. Board Consideration of Application.

The adopted amendment to §363.31 provides that if the applicant has received an obligation of federal funds by USDA-RD that would duplicate funding from the Board for the same project, as evidenced in writing from the USDA-RD, or if the applicant has canceled such an obligation, the executive administrator shall not submit the application to the Board and shall notify the applicant that its application will no longer be considered for this reason, unless good cause is shown that the application should be submitted to the Board. The executive administrator may submit an application to the Board for a project that is jointly funded with the Board's funds and by federal funds by USDA-RD, provided that the Board's funding will not result in the de-obligation of federal funds with USDA-RD. The purpose of this amendment is to avoid an applicant's cancellation of its obligation from USDA-RD and the de-obligation of federal funds such that those federal funds cannot be used by USDA-RD on other projects in Texas.

PUBLIC COMMENTS.

No comments were received regarding the proposed amendments.

DIVISION 2. GENERAL APPLICATION PROCEDURES

31 TAC §363.12

STATUTORY AUTHORITY.

The amendments are adopted under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §§15.102, 15.603, 15.604, 15.605, 15.958, 15.977, and 15.995 which authorize the Board to adopt rules regarding the financial assistance programs affected by this rulemaking.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101353
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: April 28, 2011
Proposal publication date: February 25, 2011
For further information, please call: (512) 463-8061

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DIVISION 3. FORMAL ACTION BY THE BOARD

31 TAC §363.31

STATUTORY AUTHORITY.

The amendments are adopted under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §§15.102, 15.603, 15.604, 15.605, 15.958, 15.977, and 15.995 which authorize the Board to adopt rules regarding the financial assistance programs affected by this rulemaking.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101354
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: April 28, 2011
Proposal publication date: February 25, 2011
For further information, please call: (512) 463-8061

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CHAPTER 371. DRINKING WATER STATE REVOLVING FUND

SUBCHAPTER D. APPLICATION FOR ASSISTANCE

31 TAC §371.31, §371.32

The Texas Water Development Board ("TWDB" or "Board") adopts amendments pertaining to Chapter 371, §371.31 and §371.32, concerning Drinking Water State Revolving Fund, without changes to the proposed text as published in the February 25, 2011, issue of the *Texas Register* (36 TexReg 1242).

The amendments are adopted in order to require information from an applicant for financial assistance about other sources of funding for the project, and to disapprove a commitment to an applicant for financial assistance if federal funds have been obligated for the same project by the United States Department of Agriculture-Rural Development ("USDA-RD").

SECTION BY SECTION DISCUSSION OF ADOPTED AMENDMENTS.

§371.31. Timeliness of Application and Required Application Information.

The adopted amendment to §371.31 adds to the required information in an application for financial assistance that if additional funds are necessary to complete the project, or if the applicant has applied for and/or received a commitment from any other funding source for the project or any aspect of the project, an applicant shall submit a listing of those sources, including total project costs, financing terms, and current status of the funding

requests. The TWDB application already requires this information, so the adopted rule documents a current procedure.

§371.32. Review of Applications for Financial Assistance.

The adopted amendment to §371.32 provides that if the applicant has received an obligation of federal funds by USDA-RD that would duplicate funding from the Board for the same project, as evidenced in writing from the USDA-RD, or if the applicant has canceled such an obligation, the executive administrator shall not submit the application to the Board and shall notify the applicant that its application will no longer be considered for this reason, unless good cause is shown that the application should be submitted to the Board. The executive administrator may submit an application to the Board for a project that is jointly funded with the Board's funds and by federal funds by USDA-RD, provided that the Board's funding will not result in the de-obligation of federal funds with USDA-RD. The purpose of this amendment is to avoid an applicant's cancellation of its obligation from USDA-RD and the de-obligation of federal funds such that those federal funds cannot be used by USDA-RD on other projects in Texas.

PUBLIC COMMENTS.

No comments were received regarding the proposed amendments.

STATUTORY AUTHORITY.

The amendments are adopted under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §§15.102, 15.603, 15.604, 15.605, 15.958, 15.977, and 15.995 which authorize the Board to adopt rules regarding the financial assistance programs affected by this rulemaking.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101355
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: April 28, 2011
Proposal publication date: February 25, 2011
For further information, please call: (512) 463-8061

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CHAPTER 375. CLEAN WATER STATE REVOLVING FUND
SUBCHAPTER D. APPLICATION FOR ASSISTANCE

31 TAC §375.41, §375.42

The Texas Water Development Board ("TWDB" or "Board") adopts amendments to Chapter 375, §375.41 and §375.42, concerning Clean Water State Revolving Fund, without changes to the proposed text as published in the February 25, 2011, issue of the *Texas Register* (36 TexReg 1243).

The amendments are adopted in order to require information from an applicant for financial assistance about other sources of funding for the project, and to disapprove a commitment to an applicant for financial assistance if federal funds have been obligated for the same project by the United States Department of Agriculture-Rural Development ("USDA-RD").

SECTION BY SECTION DISCUSSION OF ADOPTED AMENDMENTS.

§375.41. Timeliness of Application and Required Application Information.

The adopted amendment to §375.41 adds to the required information in an application for financial assistance that if additional funds are necessary to complete the project or if the applicant has applied for and/or received a commitment from any other funding source for the project or any aspect of the project, an applicant shall submit a listing of those sources, including total project costs, financing terms, and current status of the funding requests. The TWDB application already requires this information, so the adopted rule documents a current procedure.

§375.42. Review of Applications.

The adopted amendment to §375.42 provides that if the applicant has received an obligation of federal funds by USDA-RD that would duplicate funding from the Board for the same project, as evidenced in writing from the USDA-RD, or if the applicant has canceled such an obligation, the executive administrator shall not submit the application to the Board and shall notify the applicant that its application will no longer be considered for this reason, unless good cause is shown that the application should be submitted to the Board. The executive administrator may submit an application to the Board for a project that is jointly funded with the Board's funds and by federal funds by USDA-RD, provided that the Board's funding will not result in the de-obligation of federal funds with USDA-RD. The purpose of this amendment is to avoid an applicant's cancellation of its obligation from USDA-RD and the de-obligation of federal funds such that those federal funds cannot be used by USDA-RD on other projects in Texas.

PUBLIC COMMENTS.

No comments were received regarding the proposed amendments.

STATUTORY AUTHORITY.

The amendments are adopted under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §§15.102, 15.603, 15.604, 15.605, 15.958, 15.977, and 15.995 which authorize the Board to adopt rules regarding the financial assistance programs affected by this rulemaking.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101356

Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: April 28, 2011
Proposal publication date: February 25, 2011
For further information, please call: (512) 463-8061

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CHAPTER 384. RURAL WATER ASSISTANCE FUND
SUBCHAPTER B. APPLICATION PROCEDURES

31 TAC §384.22, §384.24

The Texas Water Development Board ("TWDB" or "Board") adopts amendments to Chapter 384, §384.22 and §384.24, concerning Rural Water Assistance Fund Application Procedures, without changes to the proposed text as published in the February 25, 2011, issue of the *Texas Register* (36 TexReg 1245).

The amendments are adopted in order to require information from an applicant for financial assistance about other sources of funding for the project, and to disapprove a commitment to an applicant for financial assistance if federal funds have been obligated for the same project by the United States Department of Agriculture-Rural Development ("USDA-RD").

SECTION BY SECTION DISCUSSION OF ADOPTED AMENDMENTS.

§384.22. Application for Assistance.

The adopted amendment to §384.22 adds to the required information in an application for financial assistance that if additional funds are necessary to complete the project, or if the applicant has applied for and/or received a commitment from any other funding source for the project or any aspect of the project, an applicant shall submit a listing of those sources, including total project costs, financing terms, and current status of the funding requests. The TWDB application already requires this information, so the adopted rule documents a current procedure.

§384.24. Board Consideration of Application.

The adopted amendment to §384.24 provides that if the applicant has received an obligation of federal funds by USDA-RD that would duplicate funding from the Board for the same project, as evidenced in writing from the USDA-RD, or if the applicant has canceled such an obligation, the executive administrator shall not submit the application to the Board and shall notify the applicant that its application will no longer be considered for this reason, unless good cause is shown that the application should be submitted to the Board. The executive administrator may submit an application to the Board for a project that is jointly funded with the Board's funds and by federal funds by USDA-RD, provided that the Board's funding will not result in the de-obligation of federal funds with USDA-RD. The purpose of this amendment is to avoid an applicant's cancellation of its obligation from USDA-RD and the de-obligation of federal funds such that those federal funds cannot be used by USDA-RD on other projects in Texas.

PUBLIC COMMENTS.

No comments were received regarding the proposed amendments.

STATUTORY AUTHORITY.

The amendments are adopted under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §§15.102, 15.603, 15.604, 15.605, 15.958, 15.977, and 15.995 which authorize the Board to adopt rules regarding the financial assistance programs affected by this rulemaking.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101357
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: April 28, 2011
Proposal publication date: February 25, 2011
For further information, please call: (512) 463-8061

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 708. MEDICAID TARGETED CASE MANAGEMENT PROGRAM
SUBCHAPTER A. PROGRAM REQUIREMENTS

40 TAC §§708.1 - 708.4

The Health and Human Services Commission adopts, on behalf of the Department of Family and Protective Services (DFPS), the repeal of §§708.1 - 708.4, without changes to the proposal as published in the February 18, 2011, issue of the *Texas Register* (36 TexReg 908).

DFPS is deleting Chapter 708, Medicaid Targeted Case Management (TCM) Program, because DFPS stopped claiming Title XIX funds for TCM effective June 30, 2008, in order to implement a revised definition of case management services enacted in the Deficit Reduction Act of 2005, P.L. 109-171, and incorporated in corresponding regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). Pursuant to those rules, the case management services delivered by Child Protective Services (CPS) no longer met the requirements for claiming because child protective services are considered to be the direct services of State child welfare and are not Medicaid case management services. (See 72 FR 68086.) The preamble to the CMS regulations further stated that these activities performed by child welfare/child protective services are separate and apart from the Medicaid program and that Medicaid case management services must not be used to fund the services of State child welfare/child protective services workers. While the regulations specifically discussed only CPS claims for TCM, the revised definition directly implicates TCM claiming by the Adult Protective

Services Program as well. Accordingly, Texas ceased federal claiming for any targeted case management services provided by DFPS effective June 30, 2008.

The repeals will function by ensuring that agency rules are current.

No comments were received regarding adoption of the repeals.

The repeals are adopted under Human Resources Code (HRC) §40.0505 and Government Code §531.0055, which provide that the Health and Human Services Executive Commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including the Department of Family and Protective Services; and HRC §40.021, which provides that the Family and Protective Services Council shall study and make recommendations to the Executive Commissioner and the Commissioner regarding rules governing the delivery of services to persons who are served or regulated by the department.

The repeals implement HRC §40.0505 and Government Code §531.0055.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on April 8, 2011.

TRD-201101348
Gerry Williams
General Counsel
Department of Family and Protective Services
Effective date: May 1, 2011
Proposal publication date: February 18, 2011
For further information, please call: (512) 438-3437

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REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Reviews

Texas Department of Insurance, Division of Workers' Compensation

Title 28, Part 2

Pursuant to the notice of proposed rule review published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11715), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on December 24, 2010, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 137, Disability Management.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and those sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 137. The completion of the review of this chapter concludes the rule review process.

TRD-201101394
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: April 13, 2011

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Pursuant to the notice of proposed rule review published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11715), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on December 24, 2010, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 156, Representation of Parties Before the Agency--Carrier's Austin Representative.

The Department considered, among other things, whether the reasons for adoption of this rule continue to exist. The Department received no written comments regarding the review of its rule.

The Department has determined that the reasons for adopting the remaining section continue to exist and this section is retained in its present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 156. The completion of the review of this chapter concludes the rule review process.

TRD-201101395
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: April 13, 2011

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Pursuant to the notice of proposed rule review published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11715), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on December 24, 2010, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 160, Worker's Health and Safety--General Provisions.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and those sections are retained in their present form.. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 160. The completion of the review of this chapter concludes the rule review process.

TRD-201101396
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: April 13, 2011

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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.

Coastal Coordination Council

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 501. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of March 30, 2011, through April 6, 2011. 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 §§506.25, 506.32, and 506.41, the public comment period extends 30 days from the date published on the Coastal Coordination Council website. The notice was published on the website on April 14, 2011. The public comment period for this project will close at 5:00 p.m. on May 13, 2011.

FEDERAL AGENCY ACTIONS:

Applicant: Marine Storage, LLC; Location: The project is located along the banks of the Port Mansfield Channel Harbor in Willacy County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Port Mansfield, Texas. Approximate: Latitude: 26.548981 North; Longitude: -97.432162 West. Project Description: The applicant is proposing to deepen and widen an existing shallow water basin located within the Port Mansfield Harbor as follows: Deepen two areas (Dredge Area 1 and Dredge Area 2) to a depth of -6.0 feet. Approximately 0.3 acre of uplands, totaling 5,092 cubic yards, located above the Mean High Water (MHW) line will be excavated during project construction. Approximately 0.16 acres of jurisdictional waters of the U.S., totaling 4,333 cubic yards, located below MHW, will be excavated during project construction. The total area to be dredged is 0.46 acre. CMP Project No.: 11-0307-F1. Type of Application: U.S.A.C.E. permit application #SWG-2010-00886 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: City of Corpus Christi; Location: The project is located in Packery Channel and the Gulf of Mexico, on the northernmost end of North Padre Island, in Nueces County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Crane Islands SW, Texas. Project Description: The applicant proposes to conduct maintenance dredging of approximately 300,000 CY of beach compatible sand within Packery Channel, with subsequent placement along the Gulf beach between Packery Channel and Viento Del Mar (approximately 1.4 miles). Maintenance dredging would be conducted using hydraulic methods with the material conveyed and ultimately discharged through a temporary dredge pipeline on the Gulf beach. No changes to the authorized channel dimensions are proposed. This project involves maintenance dredging of a previously constructed channel with beneficial use of the material along the Gulf beach. Wetlands and other special aquatic sites are not present within the project area. No impacts to wetlands and/or special aquatic sites are anticipated. CMP Project No.: 11-0308-F1. Type of Application: U.S.A.C.E. permit application #SWG-2011-00159 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action or activity is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above, including a copy of the consistency certifications or consistency determinations for inspection may be obtained from Ms. Kate Zultner, Consistency Review Specialist, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or via email at kate.zultner@glo.texas.gov. Comments should be sent to Ms. Zultner at the above address or by email.

TRD-201101377
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: April 12, 2011

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Comptroller of Public Accounts

Certification of the Average Taxable Price of Gas and Oil - March 2011

The Comptroller of Public Accounts, administering agency for the collection of the Crude Oil Production Tax, has determined that the average taxable price of crude oil for reporting period March 2011, as required by Tax Code, §202.058, is $71.44 per barrel for the three-month period beginning on December 1, 2010, and ending February 28, 2011. Therefore, pursuant to Tax Code, §202.058, crude oil produced during the month of March 2011, from a qualified Low-Producing Oil Lease, is not eligible for exemption from the crude 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 that the average taxable price of gas for reporting period March 2011, as required by Tax Code, §201.059, is $3.34 per mcf for the three-month period beginning on December 1, 2010, and ending February 28, 2011. Therefore, pursuant to Tax Code, §201.059, gas produced during the month of March 2011, from a qualified Low-Producing Well, is eligible for 25% 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 March 2011, is $103.02 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 March 2011, 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 March 2011, is $4.07 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 March 2011, from a qualified low-producing gas well.

Inquiries should be directed to Bryant K. Lomax, Manager, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711-3528.

TRD-201101367
Ashley Harden
General Counsel
Comptroller of Public Accounts
Filed: April 11, 2011

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Notice of Contract Award

The Comptroller of Public Accounts (Comptroller) announces the following contract award:

The notice of request for proposals (RFP #199e) was published in the January 21, 2011, issue of the *Texas Register* (36 TexReg 294).

The contractor will provide all-capital core passive U.S. equity investment management services to the Comptroller and the Texas Prepaid Higher Education Tuition Board.

The contract was awarded to RhumbLine Advisers, 30 Rowes Wharf, Suite 420, Boston, MA 02110-3326. The total amount of the contract is based on the value of assets managed. The term of the contract is April 5, 2011 through August 31, 2016, with option for 2 additional 1-year extensions, 1 year at a time.

TRD-201101358
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: April 8, 2011

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 04/18/11 - 04/24/11 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 04/18/11 - 04/24/11 is 18% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

TRD-201101379
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: April 12, 2011

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Texas Education Agency

Request for Applications Concerning Texas Title I Priority Schools, Cycle 2

Eligible Applicants. The Texas Education Agency (TEA) is requesting applications under Request for Applications (RFA) #701-11-105 from local educational agencies (LEAs) on behalf of eligible campuses that qualify as either Tier I, Tier II, or Tier III schools. An LEA with multiple eligible campuses must submit an application for each eligible campus.

A Tier I school meets one of the following criteria: A) Is any school that receives funds under the No Child Left Behind Act of 2001 (NCLB), Title I, Part A, that is either 1) among the lowest-achieving 5 percent by academic performance (without the use of the Texas Projection Measure) of schools in improvement, corrective action, or restructuring, or 2) if the school is a high school, has had a graduation rate below 60 percent for the 2 consecutive school years 2007-2008 and 2008-2009 or an average graduation rate of less than 60 percent over the same period; or B) Is any Title I eligible elementary campus (based on 2010-2011 data) that either 1) is among the lowest-achieving 20 percent that is not higher than the highest-achieving persistently lowest-achieving (PLA) campus identified in Tier I, or 2) is a campus not making adequate yearly progress (AYP) for 2 consecutive years (2008-2009 and 2009-2010) and not higher than the highest-achieving PLA campus identified in Tier I.

A Tier II school meets one of the following criteria: A) Is any secondary school that is eligible for, but does not receive, Title I funds (based on 2010-2011 data) that is either 1) among the lowest-achieving 5 percent of such schools by academic performance (without the use of the Texas Projection Measure), or 2) if the school is a high school, has had a graduation rate below 60 percent for the 2 consecutive school years 2007-2008 and 2008-2009 or an average graduation rate of less than 60 percent over the same period; or B) Is any Title I eligible secondary campus that either 1) is among the lowest-achieving 20 percent that is not higher than the highest-achieving PLA campus identified in Tier II, or 2) is a campus not making AYP for 2 consecutive years (2008-2009 and 2009-2010) and not higher than the highest-achieving PLA campus identified in Tier II, or 3) is a high school that has a graduation rate that is less than 60 percent for 2 consecutive years (2007-2008 and 2008-2009), or an average graduation rate less than 60 percent for the same period, that is in the lowest 20 percent of all secondary schools or has not made AYP for 2 consecutive years (2008-2009 and 2009-2010).

A Tier III school meets one of the following criteria: A) Is any Title I school in improvement, corrective action, or restructuring that is not identified as a Tier I eligible campus; or B) Is any Title I eligible campus (based on 2010-2011 data) not identified in Tier I or Tier II and not making AYP for two consecutive years (2008-2009 and 2009-2010).

Description. The purpose of the Texas Title I Priority Schools grant program is to provide funding to LEAs for use in Title I schools identified for improvement, corrective action, or restructuring and other eligible schools that demonstrate the greatest need for the funds and the strongest commitment to use the funds to provide adequate resources to substantially raise the achievement of their students so as to enable the schools to make AYP and, as applicable, exit improvement status. School improvement funds are to be focused on Tier I and Tier II

schools. An LEA may also use school improvement funds in Tier III schools.

Dates of Project. The Texas Title I Priority Schools grant program will be implemented during the 2011-2012, 2012-2013, and 2013-2014 school years. Applicants should plan for a starting date of no earlier than August 1, 2011, and an ending date of no later than June 30, 2014. For all tiers, pre-implementation costs, which are requested as part of the Year 1 budget, are allowable back to the date the grant award is issued.

Project Amount. The number of projects funded will depend on the number of eligible applicants that apply in each tier. Each project will receive a maximum of $6 million for the 2011-2012, 2012-2013, and 2013-2014 project period. This project is funded 100 percent with federal funds.

Waivers. As part of the application for funding, the state applied for, and received approval of, three waivers from the U.S. Department of Education. Specifically, TEA applied for waiver requests on behalf of Texas LEAs to do the following: 1) Waive the General Education Provisions Act (20 U.S.C. §1225(b)), Section 421(b), to extend the period of availability of school improvement funds for the state and all of its eligible LEAs to September 30, 2014; 2) Waive the Elementary and Secondary Education Act (ESEA), Section 1116(b)(12), to permit LEAs to allow Tier I schools that will implement a turnaround or restart model to "start over" in the school improvement timeline; and 3) Waive the 40 percent poverty eligibility threshold in the ESEA, Section 1114(a)(1), to permit LEAs to implement a schoolwide program in a Tier I school that does not meet the poverty threshold. The waivers will increase the quality of instruction for students and improve the academic achievement of students in eligible schools by enabling an LEA to use more effectively the school improvement funds to implement one of the four school intervention models in its Tier I or Tier II schools and to carry out school improvement activities in its Tier III schools.

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 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.

Applicants' Technical Assistance. A prerecorded webinar will be posted to the TEA Grant Opportunities web page at http://burleson.tea.state.tx.us/GrantOpportunities/forms. In the "Select 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. The webinar will cover topics such as grant program requirements, the school intervention models, technical assistance available to applicants and grantees, and application submission procedures.

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.

Requesting the Application. RFAs are no longer available in print. The announcement letter and complete RFA will be posted on the TEA Grant Opportunities web page at http://burleson.tea.state.tx.us/GrantOpportunities/forms for viewing and downloading. In the "Select 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.

Further Information. For clarifying information about the RFA, contact Randy Willis, Division of NCLB Program Coordination, Texas Education Agency, (512) 463-9374. In order to assure that no prospective applicant may obtain a competitive advantage because of acquisition of information unknown to other prospective applicants, any and all questions must be submitted in writing to the TEA contact persons identified in Part 2: Program Guidelines of the RFA. All questions and the written answers thereto will be posted on the TEA website in the format of Frequently Asked Questions (FAQs) at http://burleson.tea.state.tx.us/GrantOpportunities/forms. In the "Select 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 received in the TEA Document Control Center by 5:00 p.m. (Central Time), Tuesday, June 21, 2011, to be eligible to be considered for funding.

TRD-201101397
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: April 13, 2011

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **May 23, 2011.** TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on May 23, 2011.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: AB Grocery, Incorporated; DOCKET NUMBER: 2010-1708-PST-E; IDENTIFIER: RN102268620; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.242(9) and Texas Health and Safety Code (THSC), §382.085(b), by failing to post operating instructions conspicuously on the front of each gasoline dispensing pump equipped with a Stage II vapor recovery system; 30 TAC §115.245(2) and THSC, §382.082(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months and the Stage II vapor space manifolding and dynamic back pressure at least once every 36 months or upon major system replacement or modification, whichever occurs first; 30 TAC §115.246(1) and THSC, §382.085(b), by failing to maintain Stage II records at the station and make them available for review upon request by agency personnel; PENALTY: $6,252; ENFORCEMENT COORDINATOR: Bridgett Lee, (512) 239-2565; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(2) COMPANY: Alcorp, Incorporated dba Webberville Grocery; DOCKET NUMBER: 2011-0118-PST-E; IDENTIFIER: RN101491777; LOCATION: Webberville, Travis County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.49(a)(2) and TWC, §26.3475(d), by failing to operate and maintain a corrosion protection system in a manner that will ensure that corrosion protection will be continuously provided to all underground metal components of the underground storage tank system; PENALTY: $1,875; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5712, (512) 339-2929.

(3) COMPANY: Anton N. Zaghloul dba Nicki's Kwik Stop; DOCKET NUMBER: 2011-0210-PST-E; IDENTIFIER: RN101563823; LOCATION: Watauga, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) 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 month (not to exceed 35 days between each monitoring); PENALTY: $1,925; ENFORCEMENT COORDINATOR: Michael Meyer, (512) 239-4492; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118, (817) 588-5800.

(4) COMPANY: City of Arcola; DOCKET NUMBER: 2010-0710-MWD-E; IDENTIFIER: RN102096815; LOCATION: Fort Bend County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0013367001, Interim I Effluent Limitations and Monitoring Requirements, Numbers 1 and 6, by failing to comply with permitted effluent limits; TWC, §26.121(a)(1), 30 TAC §305.125(1), and TPDES Permit Number WQ0013367001, Interim I Effluent Limitations and Monitoring Requirements, Number 1, by failing to comply with permitted effluent limits; PENALTY: $29,040; ENFORCEMENT COORDINATOR: Heather Brister, (254) 761-3034; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(5) COMPANY: City of Big Lake; DOCKET NUMBER: 2011-0048-MSW-E; IDENTIFIER: RN102328176; LOCATION: Big Lake, Reagan County; TYPE OF FACILITY: landfill; RULE VIOLATED: 30 TAC §330.133(b) and Municipal Solid Waste (MSW) Permit Number 86B, Site Operating Plan IV. 4.7.3, Waste Unloading Procedures, by failing to prevent the unloading of waste in unauthorized areas at the facility; 30 TAC §330.139(1) and MSW Permit Number 86B, Site Operating Plan, IV. 4.10, Control of Windblown Waste and Litter, by failing to control windblown waste and litter from the active working face; 30 TAC §330.165(a) - (c), MSW Permit Number 86B, Site Operating Plan, IV.4.23, Landfill Cover, by failing to provide adequate daily, weekly and intermediate cover; 30 TAC §330.143(b)(5) and MSW Permit Number 86B, Site Operating Plan IV. 4.12, Landfill Markers and Benchmark, by failing to apply intermediate grid markers as required; PENALTY: $3,937; ENFORCEMENT COORDINATOR: Michael Meyer, (512) 239-4492; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7013, (325) 655-9479.

(6) COMPANY: City of Cranfills Gap; DOCKET NUMBER: 2010-1923-MWD-E; IDENTIFIER: RN101916492; LOCATION: Cranfills Gap, Bosque County; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0014169001, Final Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; PENALTY: $10,800; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(7) COMPANY: City of Kennard; DOCKET NUMBER: 2011-0079-MWD-E; IDENTIFIER: RN102078169; LOCATION: Kennard, Houston County; TYPE OF FACILITY: wastewater treatment system; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0011474001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; PENALTY: $6,450; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(8) COMPANY: City of Leander; DOCKET NUMBER: 2010-1978-WQ-E; IDENTIFIER: RN105526925; LOCATION: Leander, Williamson County; TYPE OF FACILITY: municipal separate storm sewer system; RULE VIOLATED: 30 TAC §281.25(b)(5), 40 Code of Federal Regulations §122.34, and Texas Pollutant Discharge Elimination System General Permit Number TXR040149, Part IV, Section B.2, by failing to submit the annual report to the executive director within 90 days of the end of each permit year; PENALTY: $1,050; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5712, (512) 339-2929.

(9) COMPANY: City of Wills Point; DOCKET NUMBER: 2010-1721-MLM-E; IDENTIFIER: RN101388973; LOCATION: Van Zandt County; TYPE OF FACILITY: municipal public water supply; RULE VIOLATED: 30 TAC §290.42(d)(2)(E), by failing to provide an air gap connection on the filter-to-waste connections; 30 TAC §290.42(d)(10)(B), by failing to design the inlet and outlet of clarification facilities so as to prevent short-circuiting of flow or the destruction of floc; 30 TAC §290.42(d)(11)(F)(iii), by failing to provide a rate of flow of backwash water that is at least 20 inches vertical rise per minute (12.5 gallons per minute (gpm) per square foot) and usually not more than 35 inches of vertical rise per minute (21.8 gpm per square foot); 30 TAC §290.42(d)(11)(F)(iv)(II), by failing to provide backwash facilities capable of expanding a mixed-media filter bed without air scour at least 25% during the backwash cycle; 30 TAC §290.42(d)(13), by failing to identify the influent, effluent, waste backwash, and chemical feed lines by the use of labels or various colors of paint; 30 TAC §290.42(f)(1)(C), by failing to provide a device on all chemical bulk storage facilities and day tanks that indicates the amount of chemical remaining in the facility or tank; 30 TAC §290.42(f)(1)(E)(ii), by failing to provide adequate containment facilities for all liquid chemical storage tanks; 30 TAC §290.42(f)(2)(D), by failing to use a chemical feed system designed to minimize the possibility of leaks and spills and provide

protection against backpressure and siphoning; 30 TAC §290.46(f)(2) and (3)(B)(iv) and (v), by failing to maintain the facility's operating records accessible for review during inspections; 30 TAC §290.46(j), by failing to obtain prior approval from the executive director before using an alternative customer service inspection certificate form; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the system's facilities and equipment; 30 TAC §290.46(m)(1)(A), by failing to inspect the interior coating of the elevated storage tanks for adequate protection to all metal surfaces on an annual basis; 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(s)(2) and (2)(A)(ii) and (B)(iv), by failing to properly calibrate equipment used for compliance testing; 30 TAC §290.110(b)(4), by failing to maintain the residual disinfectant concentration within the distribution system at a minimum of 0.5 milligrams per liter chloramine; 30 TAC §290.111(d)(2)(B), by failing to monitor the performance of the disinfection zones according to the facility's most current monitoring plan and current disinfection contact time study approval letter; 30 TAC §290.121(a) and (b), by failing to maintain an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations, describes the sampling frequency, and specifies the analytical procedures and laboratories that the facility will use to comply with monitoring; PENALTY: $14,606; SEP offset amount of $11,685 applied to Household Hazardous Waste, Electronics, and Appliance Collection Event; ENFORCEMENT COORDINATOR: Michaelle Sherlock, (210) 403-4076; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(10) COMPANY: Congress Materials LLC; DOCKET NUMBER: 2010-1930-AIR-E; IDENTIFIER: RN104961693; LOCATION: Euless, Tarrant County; TYPE OF FACILITY: rock crusher; RULE VIOLATED: 30 TAC §116.115(c), New Source Review Permit Number 28490F, Special Conditions Number 7B, and THSC, §382.085(b), by failing to obtain a change of location authorization prior to relocating the portable concrete and rock crusher; PENALTY: $1,000; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(11) COMPANY: GOOD UNITED BUSINESS, INCORPORATED dba Walter's Food Mart; DOCKET NUMBER: 2011-0017-PST-E; IDENTIFIER: RN104891775; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $5,100; ENFORCEMENT COORDINATOR: Andrea Park, (512) 239-4575; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(12) COMPANY: Harris County Municipal Utility District Number 366; DOCKET NUMBER: 2010-1571-MWD-E; IDENTIFIER: RN101399103; LOCATION: Houston, Harris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0014359001, Interim Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permit effluent limits; PENALTY: $2,980; ENFORCEMENT COORDINATOR: Heather Brister, (254) 761-3034; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(13) COMPANY: J & S Trading, Incorporated dba C Mart 6; DOCKET NUMBER: 2011-0114-PST-E; IDENTIFIER: RN104484928; LOCATION: Austin, Travis County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed more than 35 days between each monitoring); PENALTY: $1,875; ENFORCEMENT COORDINATOR: Michael Meyer, (512) 239-4492; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5712, (512) 339-2929.

(14) COMPANY: Joe Bland Construction, L.P.; DOCKET NUMBER: 2011-0116-AIR-E; IDENTIFIER: RN106049927; LOCATION: Austin, Travis County; TYPE OF FACILITY: portable rock crusher; RULE VIOLATED: 30 TAC §116.110(a) and THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization to construct and operate a rock; PENALTY: $10,000; ENFORCEMENT COORDINATOR: Heather Podlipny, (512) 239-2603; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5712, (512) 339-2929.

(15) COMPANY: KHAN, INCORPORATED dba Khan's Food Mart; DOCKET NUMBER: 2011-0141-PST-E; IDENTIFIER: RN101550192; LOCATION: Dallas, Dallas County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.248(1) and THSC, §382.085(b), by failing to ensure that at least one station representative received training in the operation and maintenance of the Stage II vapor recovery system, and each current employee receives in-house Stage II vapor recovery training; 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months; 30 TAC §115.242(3) and THSC, §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition; PENALTY: $10,046; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5825; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(16) COMPANY: Linde Gas North America LLC; DOCKET NUMBER: 2010-2061-IWD-E; IDENTIFIER: RN100217207; LOCATION: Harris County; TYPE OF FACILITY: methanol carbon monoxide, and hydrogen manufacturing; RULE VIOLATED: Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0004092000, Effluent Limitations and Monitoring Requirements Number 1 for Outfall 001 and Number 2 for Outfall 002, 30 TAC §305.125(1) and TWC, §26.121(a)(1), by failing to comply with permitted effluent limits; TPDES Permit Number WQ0004092000 Monitoring and Reporting Requirements Number 1, and 30 TAC §305.125(1) and §319.1, by failing to submit a complete discharge monitoring report for the monitoring period ending December 31, 2009; 30 TAC §305.125(1) and (17) and TPDES Permit Number WQ0004092000 Chronic Biomonitoring Requirements, Reporting Number 3, by failing to submit monitoring results at the intervals specified in the permit; PENALTY: $11,118; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5886; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(17) COMPANY: Lisa Motor Lines, Incorporated; DOCKET NUMBER: 2011-0168-PST-E; IDENTIFIER: RN100638527; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: fleet refueling; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tank (UST) for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide proper release detection for the piping associated with the UST; 30 TAC §334.10(b)(1)(B), by failing to maintain UST records and make them immediately available for inspection upon request by agency

personnel; PENALTY: $2,894; ENFORCEMENT COORDINATOR: James Nolan, (512) 239-6634; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(18) COMPANY: MEHAK & HARIS LLC dba Lucky 7 Beer & Wine; DOCKET NUMBER: 2010-1962-PST-E; IDENTIFIER: RN102344892; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to ensure that all underground storage tanks are monitored in a manner which will detect a release at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,500; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5825; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(19) COMPANY: Metro World Incorporated dba Grab N Go; DOCKET NUMBER: 2011-0121-PST-E; IDENTIFIER: RN102342094; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to ensure that all underground storage tanks are monitored in a manner which will detect a release at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $1,925; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 899-8799; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(20) COMPANY: Mirando City Water Supply Corporation; DOCKET NUMBER: 2010-1998-MWD-E; IDENTIFIER: RN101455624; LOCATION: Webb County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §30.350(d) and §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014207001, Other Requirements Number 1, by failing to have a certified operator with the proper level of license operating the facility and the collection system; 30 TAC §305.125(5) and TPDES Permit Number WQ0014207001, Operational Requirements Number 1, by failing to ensure that the facility and all of its systems of collection, treatment, and disposal are properly operated and maintained; PENALTY: $6,500; ENFORCEMENT COORDINATOR: Thomas Jecha, (512) 239-2576; REGIONAL OFFICE: 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

(21) COMPANY: Moore Water Supply Corporation; DOCKET NUMBER: 2010-2070-PWS-E; IDENTIFIER: RN101234417; LOCATION: Moore, Frio County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.109(f)(3) and §290.122(b)(2)(A) and THSC, §341.031(a), by failing to comply with the maximum contaminant level (MCL) for total coliform and failed to provide public notification of the MCL exceedance for the month of October 2009; 30 TAC §290.109(c)(2)(A)(ii) and §290.122(c)(2)(A) and THSC, §341.033(d), by failing to collect routine distribution water samples for coliform analysis and failing to provide public notification of the failure to sample for the months of May and August 2010; PENALTY: $892; ENFORCEMENT COORDINATOR: Kelly Wisian, (512) 239-2570; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(22) COMPANY: National Oilwell Varco, L.P.; DOCKET NUMBER: 2011-0169-IWD-E; IDENTIFIER: RN100211457; LOCATION: Houston, Harris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0003994000, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; 30 TAC §305.125(17) and §319.1 and TPDES Permit Number WQ0003994000, Monitoring and Reporting Requirements Number 1, by failing to submit complete effluent monitoring results at the intervals specified in the permit; PENALTY: $1,529; ENFORCEMENT COORDINATOR: Thomas Jecha, P.G., (512) 239-2576; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(23) COMPANY: NORTH ATLANTIC TRADING, INCORPORATED dba Beer Barn; DOCKET NUMBER: 2010-2062-PST-E; IDENTIFIER: RN101641595; LOCATION: Lake Dallas, Denton County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months and vapor space manifolding and dynamic back pressure at least once every 36 months or upon major system replacement or modification, whichever occurs first; PENALTY: $2,354; ENFORCEMENT COORDINATOR: Clinton Sims, (512) 239-6933; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(24) COMPANY: Pure Water Supply Corporation; DOCKET NUMBER: 2011-0129-PWS-E; IDENTIFIER: RN102674850; LOCATION: McLennan County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.45(b)(1)(D)(v) and THSC, §341.0315(c), by failing to provide emergency power that will deliver water at a rate of 0.35 gallons per minute per connection in the event of the loss of normal power supply; 30 TAC §290.51(a)(3) and TWC, §5.702, by failing to pay annual public health service fees, including associated late fees; PENALTY: $535; ENFORCEMENT COORDINATOR: Kelly Wisian, (512) 239-2570; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(25) COMPANY: Shell Chemical LP; DOCKET NUMBER: 2010-2072-AIR-E; IDENTIFIER: RN100211879; LOCATION: Deer Park, Harris County; TYPE OF FACILITY: chemical manufacturing; RULE VIOLATED: New Source Review Permit Numbers 3219 and PSDTX974, Special Conditions Number 1, 30 TAC §116.115(c), and THSC, §382.085(b), by failing to prevent unauthorized emissions from the OP2 Elevated Flare, the OP3 Elevated Flare, and the OP3 Ground Flare during Incident Number 143946; PENALTY: $10,000; ENFORCEMENT COORDINATOR: Rebecca Johnson, (361) 825-3420; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(26) COMPANY: Tao V. Nguyen dba Stop and Go Food Mart; DOCKET NUMBER: 2011-0145-PST-E; IDENTIFIER: RN101551687; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring); PENALTY: $2,550; ENFORCEMENT COORDINATOR: Keith Frank, (512) 239-1203; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(27) COMPANY: Tempe Water Supply Corporation; DOCKET NUMBER: 2010-1840-PWS-E; IDENTIFIER: RN101456762; LOCATION: Polk County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.39(j), by failing to notify the executive director prior to making any significant change to the facility's production, treatment, storage, pressure maintenance, or distribution system; 30 TAC §290.43(c)(6), by failing to maintain all treatment units, storage and pressure maintenance facilities, distribution system lines and related appurtenances in a watertight condition; 30 TAC §290.43(c)(1), by failing to provide a ground storage tank vent with a 16-mesh or finer corrosion resistant screen to prevent entry of animals,

birds, insects and heavy air contaminants; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the facility and its equipment; PENALTY: $1,022; ENFORCEMENT COORDINATOR: Stephen Thompson, (512) 239-2558; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(28) COMPANY: USGreentech, L.L.C. dba USGreentech; DOCKET NUMBER: 2010-1894-IHW-E; IDENTIFIER: RN104360144; LOCATION: Brady, McCulloch County; TYPE OF FACILITY: manufacture of infill material and/or colored sand; RULE VIOLATED: 30 TAC §335.4, by failing to manage industrial hazardous waste in a manner to prevent the discharge or imminent threat of discharge into or adjacent to water in the state; 30 TAC §335.9(a)(1), by failing to maintain records of industrial hazardous waste activities; PENALTY: $2,100; ENFORCEMENT COORDINATOR: Mike Pace, (817) 588-5933; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7013, (325) 655-9479.

(29) COMPANY: Vopak Terminal Galena Park, Incorporated; DOCKET NUMBER: 2010-1843-IWD-E; IDENTIFIER: RN103137790; LOCATION: Galena Park, Harris County; TYPE OF FACILITY: special warehousing and storage; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0001662000, Effluent Limitation and Monitoring Requirements Number 1 for Outfall 002, by failing to comply with permitted effluent limits; TWC, §26.121(a), 30 TAC §305.125(1), and TPDES Permit Number WQ0001662000, Effluent Limitation and Monitoring Requirements Number 1 for Outfall 002, by failing to comply with permitted effluent limits; PENALTY: $17,640; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3422; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

TRD-201101381
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: April 12, 2011

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Correction of Error

The Texas Commission on Environmental Quality (TCEQ) adopted an amendment to 30 TAC §101.1 in the February 25, 2011, issue of the *Texas Register* (36 TexReg 1294). TCEQ submitted the wrong definition text for paragraph (115). The definition of "Volatile organic compound" that appears on page 1304 reflects an earlier version of the paragraph that was superseded in 2010. In consequence, that incorrect language was incorporated into the Texas Administrative Code.

The definition in paragraph (115) should read as follows:

"(115) Volatile organic compound--As defined in 40 Code of Federal Regulations §51.100(s), except §51.100(s)(2) - (4), as amended on January 21, 2009 (74 FR 3441)."

The correct definition will be restored to the Texas Administrative Code on-line.

TRD-201101405

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Notice of a Public Hearing on Proposed Revisions to the State Implementation Plan

The Texas Commission on Environmental Quality (TCEQ) will conduct a public hearing to receive comments concerning revisions to the state implementation plan (SIP), under the requirements of Texas Health and Safety Code, §382.012 and §382.013; and 40 Code of Federal Regulations §51.102 of the United States Environmental Protection Agency regulations concerning SIPs.

The proposed revision would incorporate a plan to address lead transport for the 2008 lead National Ambient Air Quality Standard (NAAQS). The proposal would meet the requirements of the Federal Clean Air Act, §110(a)(2)(D)(i), relating to the interstate transport of lead under the 2008 lead NAAQS. These revisions reference existing control strategies to reduce the concentration of lead, as well as dispersion modeling of major lead sources in Texas. Additionally, the revision verifies that the Prevention of Significant Deterioration and Nonattainment New Source Review permitting programs are being implemented in Texas and that lead is not considered a visibility-impairing pollutant.

A public hearing on this proposal will be held in Austin on May 17, 2011, at 10:00 a.m., at the TCEQ headquarters, 12100 Park 35 Circle, Building F, Room 2210. The hearing will be structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. There will be no open discussion during the hearing; however, TCEQ staff will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Shelley Naik with the Air Quality Division at (512) 239-1536. Requests should be made as far in advance as possible.

Comments may be submitted to Shelley Naik, MC 206, Air Quality Division, Chief Engineer's Office, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-5687. Electronic comments may be submitted at www5.tceq.texas.gov/rules/ecomments/. File size restrictions may apply to comments being submitted via the eComments system. All comments pertaining to the Lead Transport Plan for the 2008 Lead NAAQS SIP revision should reference Project Number 2011-005-SIP-NR. The comment period closes on May 23, 2011. Copies of the proposed SIP revision can be obtained from the TCEQ's Web site at http://www.tceq.texas.gov/implementation/air/sip/texas-sip/criteria-pollutants/sip-lead. For further information, please contact Shelley Naik, Air Quality Planning Section, (512) 239-1536.

TRD-201101382
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: April 12, 2011

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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 **May 23, 2011.** 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 May 23, 2011.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: Aliahsan Nadia Enterprises, Inc. dba Diadem Food Mart; DOCKET NUMBER: 2009-0476-PST-E; TCEQ ID NUMBER: RN102014404; LOCATION: 3911 Diadem Lane, Kirby, Bexar County; TYPE OF FACILITY: underground storage tank (USTs) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.49(a)(4) and TWC, §26.3475(d), by failing to provide corrosion protection to all underground metal components of a UST system; 30 TAC §334.50(b)(1)(A) and TCEQ AO Docket Number 2006-0061-PST-E, Ordering Provision Numbers 2.b.i. and 2.c., by failing to monitor USTs for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring); 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to monitor the piping associated with the UST system; 30 TAC §334.50(b)(2)(A)(i)(III) and TWC, §26.3475(c)(1), by failing to test the line leak detectors at least once per year for performance and operational reliability; and 30 TAC §334.7(d)(3) and TCEQ AO Docket Number 2006-0061-PST-E, Ordering Provision Numbers 2.b.ii. and 2.c., by failing to notify the agency of any change or additional information regarding USTs within 30 days from the date of occurrence of the change or addition; PENALTY: $30,155; STAFF ATTORNEY: Xavier Guerra, Litigation Division, MC R-13, (210) 403-4016; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(2) COMPANY: Evergreen Enterprises, Inc. dba Escarpment Exxon; DOCKET NUMBER: 2010-0478-MLM-E; TCEQ ID NUMBER: RN102478609; LOCATION: 6109 West William Cannon Drive, Austin, Travis County; TYPE OF FACILITY: two underground storage tanks (USTs) and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §213.5(d)(1), by failing to provide a functioning continuous monitoring leak detection system that is capable of immediately alerting of possible leakages; 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); 30 TAC §334.42(i), by failing to inspect at least once every 60 days any sumps, manways, overspill containers, or catchment basins, to assure that their sides, bottoms, and any penetration points are maintained liquid tight; and 30 TAC §334.7(d)(3), by failing to notify the agency of any change or additional information regarding the USTs within 30 days of the occurrence of the change or addition; PENALTY: $11,356; STAFF ATTORNEY: Marshall Coover, Litigation Division, MC 175, (512) 239-0620; REGIONAL OFFICE: Austin Regional Office, 2800 South Interstate Highway 35, Suite 100, Austin, Texas 78704-5712, (512) 339-2929.

(3) COMPANY: Magic Valley Concrete LLC; DOCKET NUMBER: 2009-2072-WQ-E; TCEQ ID NUMBER: RN104693148; LOCATION: 710 East Chaplin Road, Edinburg, Hidalgo County; TYPE OF FACILITY: concrete batch plant; RULES VIOLATED: 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System (TPDES) Multi-Sector General Permit Number TXR05S230, Part III, Section A.5.(f), by failing to conduct annual employee training in 2008; 30 TAC §305.125(1) and TPDES Multi-Sector General Permit Number TXR05S230, Part III, Section A.5.(g), by failing to conduct quarterly site inspections for the final quarter of 2008 and the first three quarters of 2009; 30 TAC §305.125(1) and TPDES Multi-Sector General Permit Number TXR05S230, Part III, Section A.7., by failing to conduct the annual comprehensive compliance site evaluation in 2008; and 30 TAC §305.125(1) and TPDES Multi-Sector General Permit Number TXR05S230, Part III, Section A.3.(c), by failing to submit the non-storm water certification within 180 days of filing a Notice of Intent for permit coverage; PENALTY: $9,894; STAFF ATTORNEY: Jim Sallans, Litigation Division, MC 175, (512) 239-2053; REGIONAL OFFICE: Harlingen Regional Office, 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

TRD-201101384
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: April 12, 2011

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Notice of Request for Public Comment and Notice of a Public Meeting

The Texas Commission on Environmental Quality (TCEQ or commission) has made available for public comment a draft implementation plan concerning one total maximum daily load (TMDL) for bacteria in Guadalupe River Above Canyon Lake (Segment 1806). The TCEQ will conduct a public meeting to receive comments on the draft implementation plan.

Guadalupe River Above Canyon Lake (Segment 1806) is included in the State of Texas Clean Water Act, §303(d) list of impaired water bodies. As required by the federal Clean Water Act, §303(d), one TMDL was developed for bacteria. The TMDL was adopted by the commission on July 25, 2007, as an update to the State Water Quality Management Plan. Upon adoption by the commission, the TMDL was submitted to the United States Environmental Protection Agency (EPA) who approved the TMDL on September 25, 2007. The Implementation Plan is a flexible tool that the governmental and non-governmental agencies involved in TMDL implementation will use to guide their program management.

The TCEQ will conduct a public meeting on the draft Implementation Plan for bacteria in Guadalupe River Above Canyon Lake (Segment 1806). The purpose of the public meeting is to provide the public an opportunity to comment on the draft Implementation Plan. The commission requests comment on each of the major components of the implementation plan: description of control actions and management measures, implementation strategy and tracking, review strategy, and communication strategy. After the public comment period, TCEQ staff may revise the implementation plan, if appropriate. The final Implementation Plan will then be considered for approval by the commission. Upon approval of the Implementation Plan by the commission, the final Implementation Plan and a response to public comments will be made available on the TCEQ Web site.

The public comment meeting will be held on May 11, 2011, at 6:30 p.m., at the Upper Guadalupe River Authority, 125 Lehmann Drive, Suite 100, Kerrville, Texas 78028. At this meeting, individuals have the opportunity to present oral statements when called upon in order of registration. An agency staff member will give a brief presentation at the start of the meeting and will be available to answer questions before and after all public comments have been received.

Written comments should be submitted to Jason Leifester, Water Quality Planning Division, Texas Commission on Environmental Quality, MC 203, P.O. Box 13087, Austin, Texas 78711-3087 or faxed to (512) 239-1414. Comments may be submitted by email to *www5.tceq. texas.gov/rules/ecomments* by midnight on May 23, 2011, and should reference the *Implementation Plan for One Total Maximum Daily Load for Bacteria in Guadalupe River Above Canyon Lake Segment Number 1806.*

For further information regarding this proposed TMDL Implementation Plan, please contact Jason Leifester, (512) 239-6457 or *Jason.Leifester@tceq.texas.gov.* Copies of the draft Implementation Plan will be available and can be obtained via the commission's Web site at: *www.tceq.texas.gov/implementation/water/tmdl/tmdlnews.html* or by calling (512) 239-6682.

Persons with disabilities who have special communication or other accommodation needs who are planning to attend the meeting should contact the commission at (512) 239-6682. Requests should be made as far in advance as possible.

TRD-201101378
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: April 12, 2011

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Notice of Water Quality Applications

The following notices were issued on April 1, 2011 through April 8, 2011.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

CITY OF ATLANTA has applied for a renewal of Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0010338001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,000,000 gallons per day. The facility is located approximately 0.25 mile east of the intersection of State Highway 77 and State Highway 43, south of the City of Atlanta in Cass County, Texas 75551.

XS RANCH FUND VI LP has applied for a major amendment to TPDES Permit No. WQ0014946001 to authorize the relocation of the discharge Outfall to a point approximately 6,500 feet upstream from the current permitted location. The current permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 990,000 gallons per day. The facility will be located at 802 Sayers Road, approximately 2.3 miles northwest of the intersection of Phelan Road and Sayers Road in Bastrop County, Texas 78621.

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, toll free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201101400
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 13, 2011

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Notice of Water Rights Applications

Notices issued March 23, 2011 through March 30, 2011.

APPLICATION NO. 12510; Montgomery County Municipal Utility District No. 8, 1001 McKinney, Suite 1001, Houston, Texas 77002-6424, and Montgomery County Municipal Utility District No. 9, 1001 Fannin, Suite 2500, Houston, Texas 77002-6760, Applicants, seek authorization to use the bed and banks of the West Fork San Jacinto River (Lake Conroe), San Jacinto River Basin, to convey their present and future groundwater-based return flows for use within the Districts' service areas in Montgomery County in the San Jacinto River Basin. More information on the application and how to participate in the permitting process is given below. The application and partial fees were received on October 2, 2009. Additional information was received on October 30, November 3 and December 14, 2009, and April 7 and June 3, 2010. The application was declared administratively complete and filed with the Office of the Chief Clerk on April 12, 2010. The Executive Director completed the technical review of the application and prepared a draft permit. The draft permit, if granted, would contain special conditions including but not limited to, restricting diversions to the return flows that are actually discharged. The application, technical memoranda, and Executive Director's draft amendment are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78753. Written public comments and requests for a public meeting should be received in the Office of Chief Clerk, at the address provided in the information section below, by April 28, 2011.

APPLICATION NO. 14-1288B; William Cody Elliott and Ashley Brooke Elliott, P.O. Box 465, Christoval, Texas 76935, Applicants, seek to sever their portion of water on the South Concho River, Colorado River Basin, in Tom Green County, from Certificate of Adjudication No. 14-1307, combine it with Certificate of Adjudication No. 14-1288, and seek to move the diversion point and place of use to those evidenced in Certificate No. 14-1288 in Tom Green County. More information on the application and how to participate in the permitting process is given below. The application and a portion of the fees were received on July 27, 2009. Additional information and fees were received on December 11, 2009, and February 8 and March 18, 2010. The application was declared administratively complete and filed with the Office of the Chief Clerk on August 4, 2010. The Executive Director has completed the technical review of the application and prepared a draft order and amendment. The draft amendment, if granted, would include special conditions including, but not limited to, streamflow restrictions. The application, technical memoranda, and Executive Director's draft order and amendment are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78753. Written public comments and requests for a public meeting should be received in the Office of Chief Clerk, at the address provided in the information section below, by April 19, 2011.

INFORMATION SECTION

To view the complete issued notice, view the notice on our web site at www.tceq.state.tx.us/comm_exec/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the web site, type in the issued date range shown at the top of this document to obtain search results.

A public meeting is intended for the taking of public comment, and is not a contested case hearing.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) applicant's name and permit number; (3) the statement "[I/we] request a contested case hearing;" and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the Texas Commission on Environmental Quality (TCEQ) Office of the Chief Clerk at the address provided below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201101399
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: April 13, 2011

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Texas Ethics Commission

List of Late Filers

Listed below are the names of filers from the Texas Ethics Commission who did not file reports, or failed to pay penalty fines for late reports in reference to the listed filing deadline. If you have any questions, you may contact Robbie Douglas at (512) 463-5800.

Deadline: Lobby Activities Report due January 10, 2011

Andrew Scheberle, 210 Barton Springs Rd., Ste. 400, Austin, Texas 78704

Deadline: Personal Financial Statement due December 9, 2010

Daniel Rodriguez Andrade, 780 Cedar Parkway, Seguin, Texas 78155

TRD-201101362
David A. Reisman
Executive Director
Texas Ethics Commission
Filed: April 11, 2011

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Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission (HHSC) intends to submit to the Centers for Medicare and Medicaid Services (CMS) a request for a new Medicaid waiver for the Texas Dental Program, under the authority of §1915(b) of the Social Security Act. The proposed waiver effective date is March 1, 2012.

The Texas Dental Program will offer eligible Texas Medicaid and Children's Health Insurance Program members dental services statewide through a managed care model provided by licensed dental providers. Children under the age of 21 who are eligible for Medicaid Texas Health Steps Comprehensive Care Program services, including Supplemental Security Income recipients, will be able to participate in the dental program. All children in the Children's Health Insurance Program will also be eligible to participate in the dental program.

The following Medicaid recipients will not be eligible to participate in the statewide managed care dental program and will continue to receive dental services through their existing service delivery models:

Medicaid recipients age 21 and over;

All Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers or Intermediate Care Facilities for Mentally Retarded Persons; and

STAR Health Program recipients.

HHSC is requesting that the new waiver be approved for the period beginning March 1, 2012, through February 28, 2017. This new waiver will maintain cost effectiveness for waiver years 2012 through 2017.

To obtain copies of the proposed waiver renewal, interested parties may contact Christine Longoria by mail at Texas Health and Human Services Commission, P.O. Box 85200, mail code H-370, Austin, Texas 78708-5200, phone (512) 491-1152, fax (512) 491-1957, or by email at Christine.Longoria@hhsc.state.tx.us.

TRD-201101346
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: April 7, 2011

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Texas Parks and Wildlife Department

Notice of Proposed Real Estate Transactions

Land Acquisition

Tyler State Park - Smith County

In a meeting on May 26, 2011, the Texas Parks and Wildlife Commission (the Commission) will consider the acquisition of approximately one half-acre of land adjacent to Tyler State Park. At this meeting, the public will have an opportunity to comment on the proposed transaction before the Commission takes action. The meeting will start at 9:00 a.m. at the Texas Parks and Wildlife Department Headquarters, 4200 Smith School Road, Austin, Texas 78744. Prior to the meeting, public comment may be submitted to Corky Kuhlmann, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744 or by email at corky.kuhlmann@tpwd.state.tx.us or through the TPWD website at tpwd.state.tx.us.

Pipeline Easement

Tony Houseman Wildlife Management Area - Orange County

In a meeting on May 26, 2011, the Texas Parks and Wildlife Commission (the Commission) will consider the granting of an easement for an 18-inch hydrogen pipeline across the Tony Houseman Wildlife Management Area occupying approximately three acres of land. At this meeting, the public will have an opportunity to comment on the proposed transaction before the Commission takes action. The meeting will start at 9:00 a.m. at the Texas Parks and Wildlife Department Headquarters, 4200 Smith School Road, Austin, Texas 78744. Prior to the meeting, public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744 or by email at ted.hollingsworth@tpwd.state.tx.us or through the TPWD website at tpwd.state.tx.us.

Utility Easement

San Jacinto Battleground State Historic Site - Harris County

In a meeting on May 26, 2011, the Texas Parks and Wildlife Commission (the Commission) will consider the granting of an easement for a buried communications cable across the southern end of the San Jacinto Battleground State Historic Site. At this meeting, the public will have an opportunity to comment on the proposed transaction before the Commission takes action. The meeting will start at 9:00 a.m. at the Texas Parks and Wildlife Department Headquarters, 4200 Smith School Road, Austin, Texas 78744. Prior to the meeting, public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744 or by email at ted.hollingsworth@tpwd.state.tx.us or through the TPWD website at tpwd.state.tx.us.

Land Disposition

Lake Mineral Wells State Trailway - Parker County

In a meeting on May 26, 2011, the Texas Parks and Wildlife Commission (the Commission) will consider the sale of approximately 8.5 acres of land to the Union Pacific Railroad Company out of the Lake Mineral Wells Trailway, as provided for in the deed of the Trailway to the Texas Parks and Wildlife Department in 1995. At this meeting, the public will have an opportunity to comment on the proposed transaction before the Commission takes action. The meeting will start at 9:00 a.m. at the Texas Parks and Wildlife Department Headquarters, 4200 Smith School Road, Austin, Texas 78744. Prior to the meeting, public comment may be submitted to Ted Hollingsworth, Land Conservation, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744 or by email at ted.hollingsworth@tpwd.state.tx.us or through the TPWD website at tpwd.state.tx.us.

TRD-201101392
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: April 13, 2011

♦ ♦ ♦

Public Utility Commission of Texas

Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on April 8, 2011, for retail electric provider (REP) certification, pursuant to §39.352 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of DTE Energy Supply, Inc. for Retail Electric Provider Certification, Docket Number 39310.

Applicant's requested service area is for the geographic area of the entire state of Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas 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 at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Docket Number 39310.

TRD-201101386
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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Notice of Application for Service Area Exception

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on April 5, 2011, for an amendment to certificated service area for a service area exception within Dallam County, Texas.

Docket Style and Number: Application of Southwestern Public Service Company to Amend a Certificate of Convenience and Necessity for Electric Service Area Exception within Dallam County. Docket Number 39305.

The Application: Southwestern Public Service Company (SPS) filed an application for a service area boundary exception to allow SPS to provide service to a specific customer located within the certificated service area of Rita Blanca Electric Cooperative, Inc. (RBEC). RBEC has provided an affidavit of relinquishment for the proposed change.

Persons wishing to comment on the action sought or intervene should contact the Public Utility Commission of Texas no later than April 29, 2011 by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 39305.

TRD-201101385
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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Notice of Application for Waiver of Denial of Numbering Resources

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on April 8, 2011, for waiver of denial by the Pooling Administrator (PA) of Southwestern Bell Telephone Company d/b/a AT&T Texas' (AT&T Texas) request for assignment of five thousand-blocks of numbers in the San Antonio rate center.

Docket Title and Number: Petition of AT&T Texas for Waiver of Denial of Numbering Resources, Docket Number 39312.

The Application: AT&T Texas requested five (5) thousand-blocks of numbers on behalf of its customer, Texas A&M University in San Antonio, in the San Antonio rate center. AT&T Texas submitted an application to the PA for the requested blocks in accordance with the current guidelines. The PA denied the request because AT&T Texas did not

meet the months-to-exhaust and utilization criteria established by the Federal Communications Commission.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas 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, no later than April 29, 2011. Hearing and speech impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at (800) 735-2989. All comments should reference Docket Number 39312.

TRD-201101388
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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Notice of Application for Waiver of Denial of Numbering Resources

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on April 8, 2011, for waiver of denial by the Pooling Administrator (PA) of Southwestern Bell Telephone Company d/b/a AT&T Texas' (AT&T Texas) request for assignment of one thousand-block of numbers in the Roanoke rate center.

Docket Title and Number: Petition of AT&T Texas for Waiver of Denial of Numbering Resources, Docket Number 39313.

The Application: AT&T Texas requested one (1) thousand-block of numbers on behalf of its customer, CoreLogic, in the Roanoke rate center. AT&T Texas submitted an application to the PA for the requested block in accordance with the current guidelines. The PA denied the request because AT&T Texas did not meet the months-to-exhaust and utilization criteria established by the Federal Communications Commission.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas 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, no later than April 29, 2011. Hearing and speech impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at (800) 735-2989. All comments should reference Docket Number 39313.

TRD-201101389
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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Notice of Application for Waiver of Denial of Numbering Resources

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on April 8, 2011, for waiver of denial by the Pooling Administrator (PA) of Southwestern Bell Telephone Company d/b/a AT&T Texas' (AT&T Texas) request for assignment of five thousand-blocks of numbers in the Richmond-Rosenberg rate center.

Docket Title and Number: Petition of AT&T Texas for Waiver of Denial of Numbering Resources, Docket Number 39314.

The Application: AT&T Texas requested five (5) thousand-blocks of numbers on behalf of its customer, Fort Bend County in the Richmond-Rosenberg rate center. AT&T Texas submitted an application to the PA for the requested blocks in accordance with the current guidelines. The PA denied the request because AT&T Texas did not meet the months-to-exhaust and utilization criteria established by the Federal Communications Commission.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas 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, no later than April 29, 2011. Hearing and speech impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at (800) 735-2989. All comments should reference Docket Number 39314.

TRD-201101390
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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Notice of Application to Amend a Certificate of Convenience and Necessity for a Proposed Transmission Line

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on April 6, 2011, to amend a certificate of convenience and necessity for a proposed transmission line in Sabine County, Texas.

Docket Style and Number: Application of Deep East Texas Electric Cooperative, Inc. to Amend a Certificate of Convenience and Necessity for a 138-kV Transmission Line in Sabine County. Docket Number 39274.

The Application: The application of Deep East Texas Electric Cooperative, Inc. (DETEC) for a proposed 138-kV transmission line in Sabine County, Texas. The proposed project is designated as the Fairmont 138-kV Transmission Line Project. The proposed project is presented with 4 alternate routes. DETEC has designated Route 25 as its preferred route. Any route presented in the application could, however, be approved by the Commission. Depending on the route chosen, the proposed line will be 2.2 miles in length. The proposed project will be constructed on single-pole double-circuit steel structures. The total estimated cost for the project is $4,583,000. The date estimated to energize facilities is June 2012.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. The deadline for intervention in this proceeding is May 23, 2011. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 39274.

TRD-201101387
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: April 12, 2011

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South Texas Development Council

Notice of Request for Proposals

The South Texas Development Council's (STDC) Community Services Program is seeking request for proposals from potential contractors to

do energy related home repairs (ex., caulking, weather stripping, windows, doors, wall/attic insulation, and installing energy efficient appliances) for the Weatherization Assistance Program in the area of Jim Hogg, Starr, and Zapata Counties. Interested contractors may contact Jose Conde, Regional Services Planner, at (956) 722-3995 or via email at jconde@stdc.cog.tx.us in order to obtain a packet containing instructions and specifications for proposals. Prospective bidders are encouraged to attend the bidders' conference on April 15, 2011 at 1:30 p.m. at the STDC Main office.

Proposals will be opened in the presence of witnesses on May 17, 2011 at 11:00 a.m. in the conference room of the STDC Main Office located at 1002 Dickey Lane, Laredo, Texas 78043. All proposals must be received at the STDC main office by May 16, 2011 at 5:00 p.m. to be considered in the proposal process. If selected, STDC shall award a contract for one year with an option to renew for four additional years.

STDC reserves the right to reject any and all bids. STDC is an equal opportunity employer. Funding provided by the Department of Energy and Department of Health and Human Services. Awarded contracts are subject to Davis Bacon and Related Acts requirements.

TRD-201101368
Jose Conde
Regional Services Planner
South Texas Development Council
Filed: April 11, 2011

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Texas Department of Transportation

Aviation Division - Request for Proposal for Professional Engineering Services

The City of Slaton, through its agent, the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Slaton Municipal Airport during the course of the next five years through multiple grants.

Current Project: City of Slaton. TxDOT CSJ No.: 1105SLTON. Scope: Provide engineering/design services to rehabilitate and mark Runway 18-36; rehabilitate and mark partial parallel taxiway Runway 18; rehabilitate apron and stub taxiway; rehabilitate taxiway turnaround Runway 36 end; and construct concrete fueling pad.

The HUB goal for the current project is 7%. TxDOT Project Manager is Paul Slusser.

Future scope work items for engineering/design services within the next five years may include the following:

1. Construct Parallel TW and T-hangar
2. Expand South apron
3. Rehabilitate entrance road and hangar access TWs
4. Reconstruct hangar access TW

The City of Slaton reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your proposal preparation the criteria, 5010 drawing, project narrative, and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Slaton Regional Airpark." The proposal should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT Aviation Division, 125 East 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Seven completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than May 17, 2011, 4:00 p.m. Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Kelle Chancey.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluation of engineering proposals can be found at http://www.txdot.gov/business/projects/aviation.htm. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Kelle Chancey, Grant Manager. For technical questions, please contact Paul Slusser, Project Manager.

TRD-201101351
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: April 8, 2011

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Stephen F. Austin State University

Notice of Consultant Contract Award

In compliance with the provisions of Chapter 2254, Subchapter B, Texas Government Code, Stephen F. Austin State University furnishes this notice of contract award of the university's contract with Strata Information Group, 3935 Harney Street, Suite 203, San Diego, California 92110. The contract is not to exceed the sum of $95,000.00. The orig-

inal contract availability notice was published in the January 21, 2011, issue of the *Texas Register* (36 TexReg 324).

No documents, films, recording, or reports of intangible results will be required to be presented by the outside consultant. Services are provided on an as-needed basis.

For further information, please call Diana Boubel, Director of Procurement, at (936) 468-4037.

TRD-201101345
Damon C. Derrick
General Counsel
Stephen F. Austin State University
Filed: April 7, 2011

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Texas State University-San Marcos

Notice of Request for Proposals to Provide Elevator Consultant Services

This notice states the intent of Texas State University-San Marcos (Texas State), pursuant to the provisions of Texas Government Code, Chapter 2254, Subchapter B, to solicit proposals to enter into a consulting services contract related to Elevator Consultant.

Proposals are due at Texas State at the location specified in the Request for Proposals (RFP) on or before 2:00 p.m. Central Daylight Savings Time on Thursday, May 12, 2011. Texas State will not accept late proposals. Proposals received after the submittal deadline will not be considered.

To respond, interested parties/consultants/consulting firms must contact the designated Texas State authorized representative in writing, as indicated below, to request a solicitation package in order to submit the information requested in this RFP, along with any other relevant information, in a clear and concise written format. For further information, or to request an RFP package, please contact Gloria Tobias via e-mail at gt04@txstate.edu.

Scope of Work:

Provide recommendations for elevator modernizations and renovations, and conduct reviews of plans and shop drawings associated with these renovations.

The consultant will be required to be available for planning assistance for new construction or new installations by providing comprehensive traffic analysis of handling capacity and waiting intervals. He will also assist in determining the size of proposed equipment and establish design criteria or technical specifications, financial estimates, recommend special services, accessibility features, and security applications.

Objectives:

Elevator consultant is necessary to oversee the work performed by the current elevator contractor, remedy any deficiencies to ensure elevators are opening at an optimal level at all times, and coordinate and schedule annual elevator inspections.

The Anticipated Schedule of Events is as follows:

* Issuance of RFP and Posting to the Electronic State Business Daily - April 14, 2011;

* Questions Due - May 5, 2011, at 2:00 p.m. CDT

* Official Responses to Questions Received - May 19, 2011, or as soon thereafter as practical;

* Proposals Due - May 12, 2011, at 2:00 p.m. CDT;

* Obtain Approval to Award Contract(s) - May 27, 2011, or as soon thereafter as practical;

* Contract Execution - May 27, 2011, or as soon thereafter as practical; and

* Commencement of Project Activities - June 1, 2011, or as soon thereafter as practical.

Texas State reserves the right to adjust the above schedule at its sole discretion, if determined to be in the university's best interests, as it deems fit.

Evaluation and Award Procedure:

The award for the described consulting services, if made, will be based on "best value" criteria by the process indicated in the RFP. Texas State will make the final decision regarding the award of contracts. Texas State reserves the right, if deemed in the university's best interests and at its sole discretion, to:

* award one or more contracts under this RFP;

* to accept or reject any or all proposals submitted;

* waive minor technical or process inconsistencies; or

* make no award.

A finding of fact, approved by the President of Texas State, for the need for these consultant services has been obtained.

TRD-201101398
Robert C. Moerke
Director of Contract Compliance
Texas State University-San Marcos
Filed: April 13, 2011

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Open Meetings

Statewide agencies and regional agencies that extend into four or more counties post meeting notices with the Secretary of State.

Meeting agendas are available on the *Texas Register*'s Internet site:
http://www.sos.state.tx.us/open/index.shtml

Members of the public also may view these notices during regular office hours from a computer terminal in the lobby of the James Earl Rudder Building, 1019 Brazos (corner of 11th Street and Brazos) Austin, Texas. To request a copy by telephone, please call 512-463-5561. Or request a copy by email: register@sos.state.tx.us

For items ***not*** available here, contact the agency directly. Items not found here:

- minutes of meetings
- agendas for local government bodies and regional agencies that extend into fewer than four counties
- legislative meetings not subject to the open meetings law

The Office of the Attorney General offers information about the open meetings law, including Frequently Asked Questions, the *Open Meetings Act Handbook*, and Open Meetings Opinions.
http://www.oag.state.tx.us/open/index.shtml

The Attorney General's Open Government Hotline is 512-478-OPEN (478-6736) or toll-free at (877) OPEN TEX (673-6839).

Additional information about state government may be found here:
http://www.texas.gov

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Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

How to Use the Texas Register

Information Available: The 14 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.

Secretary of State - opinions based on the election laws.

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.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

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.

Review of Agency Rules - notices of state agency rules review.

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 36 (2011) is cited as follows: 36 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 "36 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 36 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, Room 245, 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 ***Register*** is available in an .html version as well as a .pdf (portable document format) 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 following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

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
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
40 TAC §3.704.....950 *(P)*